

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02598

Reg. Dist. No. 74

## 1. PLACE OF DEATH:

County Carral  
 City or town Springfield St. Hosp. Sykesville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? April 19. 39  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution? April 19. 39.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County \_\_\_\_\_  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 2906 Cold Spring Lane  
 (If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3.(a) FULL NAME

Ann Watts Hiken

## 3.(b) Social Security Number

4. Sex Fem. 5. Color or race Wh. 6.(a) Single, married, widowed, or divorced Single  
 6.(b) Name of husband or wife \_\_\_\_\_  
 6.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) Mar. 29, 1877  
 8. AGE: Years 70 Months 11 Days 6 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Maryland  
 (Town, county, and state)  
 10. Usual occupation housework  
 11. Industry or business \_\_\_\_\_  
 12. Name George Bruce Aiken  
 13. Birthplace U.S.  
 14. Maiden name Mary Holvington  
 15. Birthplace md

16. Informant sister: Mrs. Katherine Aiken  
 Address 2906 Cold Spring Lane, Baltimore, Md.  
 17. Burial Date thereof Mar. 8, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Cathedral  
 Location Baltimore Md.  
 18. Funeral director H. H. Mears & Son  
 Address 805 N. Calvert St. Baltimore  
 19. Mar 6 1948 C. Mary New  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 5 1948 at 4:50 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 19 1939 to March 5 1948  
 and that I last saw him alive on March 4 1948

Immediate cause of death Lung Abscess  
 DURATION 1 week

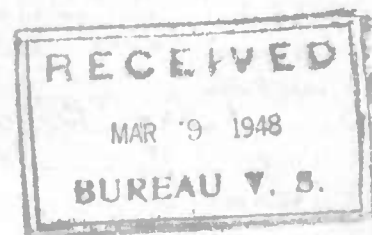
Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions Epilepsy with Cerebral 9 years  
Arteriosclerosis  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE M. Virginia Beyer M.D.  
Sykesville, Md. M. D. or other \_\_\_\_\_  
 Address \_\_\_\_\_ Date signed 3-5-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02599

Reg. Dist. No. 75

## 1. PLACE OF DEATH:

County Carroll  
 City or town Rural Millers  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 months  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll  
 City or town Rural Millers  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Richard Eugene Ayres

## 3. (b) Social Security Number

None

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Single

## 6. (b) Name of husband or wife

None

## 7. Birth date of deceased (mo., day, yr.)

Dec 15, 1947

## 6. (c) If alive, give age \_\_\_\_\_ years

## 8. AGE:

Years

Months

Days

If less than one day

228

hrs.

min.

## 9. Birthplace

Millers Carroll Maryland  
(Town, county, and state)

## 10. Usual occupation

None

## 11. Industry or business

## MOTHER FATHER

## 12. Name

John Ayres

## 13. Birthplace

Millers Carroll Maryland

## 14. Maiden name

Elva Mae Bailey

## 15. Birthplace

North Carolina

## 16. Informant

John Ayres

## Address

Millers, Maryland

## 17.

Burial

## Date thereof

3-13-48

(Burial, cremation, or removal. Which?)

(month) (day) (year)

## Cemetery or crematory

Academy

## Location

Alesia

## 18. Funeral director

James Wink's Sons

## Address

Manchester, Md

## 19.

Mar. 12 1948Mo. H. P. P. Danner  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 12 1948 at 12 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

March 12 1948 to March 12 1948and that I last saw him alive on March 12 1948

## Immediate cause of death

Infantile Diarrhea

## DURATION

1 week

## Due to

Upper Respiratory Infection

## Due to

Malnutrition  
Bacillary Dysentery 6/17/48 also

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op. \_\_\_\_\_

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_

Injured at work? \_\_\_\_\_

## 23. SIGNATURE

W. H. Foward M.D.

M. D. or other

Address Manchester, Md Date signed Mar. 13-1948

RECEIVED

MAR 19 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 70

### 1. PLACE OF DEATH:

County... **Carroll**  
City or town... **Taneytown**  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? **50 yrs**  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State... **Md** County... **Carroll**  
City or town... **Taneytown**  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

**Mrs. Blanche L. Baker**

### 3. (b) Social Security Number

**none**

4. Sex **F** 5. Color or race **W** 6.(a) Single, married, widowed, or divorced **married**  
6.(b) Name of husband or wife **George W. Baker**  
6.(c) If alive, give age years  
7. Birth date of deceased (mo., day, yr.) **Mar. 15, 1886**  
8. AGE: Years **62** Months **0** Days **6** If less than one day hrs. min.

9. Birthplace **Md**  
(Town, county, and state)  
10. Usual occupation **Housewife**  
11. Industry or business  
12. Name **Unknown**  
13. Birthplace **Unknown**  
14. Maiden name **Margaret Harmon**  
15. Birthplace **Md**

16. Informant **George W. Baker**  
Address **Taneytown, Md.**  
17. **Burial** Date thereof **Mar. 24, 1948.**  
(Burial, cremation, or removal, Which?) (month) (day) (year)  
Cemetery or crematory **Lutheran Church**  
Location **Taneytown, Md.**  
18. Funeral director **C.O. FUSS & SON**  
Address **Taneytown, Md.**  
19. **Mar. 24** 19 **48** **Ethel M. Melling**  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH **March 21** 19 **48** at **7<sup>15</sup>** A.M.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **July 26** 19 **47** to **Mar 21** 19 **48**  
and that I last saw him alive on **March 20** 19 **48**

Immediate cause of death **Spinal sclerosis**  
Due to  
Due to  
Other conditions  
(Include pregnancy within 3 months of death)

Major findings of operations  
Date of op.  
Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide Date of  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?

23. SIGNATURE **J. H. Legg** M. D. or other  
Address **Union Bridge** Date signed **3/22/48**

MARGIN RESERVED FOR BINDING

9-45-15M

V8 A16

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 25 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

 93d 02601  
 Reg. Dist. No. 74

## 1. PLACE OF DEATH:

County Carroll  
 City or town Sykesville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 12 days  
 Hospital, institution, or street address where death occurred:  
Springfield State Hospital  
 How long in hospital or institution? 12 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Montgomery  
 City or town Tokoma Park  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 821 Flower Ave.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Frederick Henry Baker

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Jessie Turner  
 7. Birth date of deceased (mo., day, yr.) February 20, 1866  
 6.(c) If alive, give age \_\_\_\_\_ years  
 8. AGE: Years 82 Months \_\_\_\_\_ Days 24 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Berkeley County, W. Va.  
 (Town, county, and state)  
 10. Usual occupation Justice of the Peace  
 11. Industry or business

12. Name Adam Baker  
 13. Birthplace Saxony, Germany  
 14. Maiden name Fredricka Painter  
 15. Birthplace Saxony, Germany

16. Informant Hospital Records  
 Address

17. Burial Date thereof Mar 18 1948  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory Green Hill Cem.  
 Location Marlinsburg, N. Va.

18. Funeral director Rogalschitz & Coffman  
 Address Marlinsburg, N. Va.

19. Mar 16 19 48 C. H. H. H.  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 19 48 at 7:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
March 3, 19 48, to March 15 19 48  
 and that I last saw him alive on March 15, 19 48

Immediate cause of death  
Generalized arteriosclerosis  
Hypertensive cardiovascular disease  
 Due to Brochopneumonia

Other conditions Psychosis with  
Cerebral arteriosclerosis  
 (Include pregnancy within 3 months of death)  
 Major findings of operations  
 Date of op.  
 Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE Joseph H. Marshall, M.D.  
Springfield State Hospital  
 Address Date signed 3/16/48

RECEIVED

MAR 18 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

450

02602

Reg. Dist. No. 21

## 1. PLACE OF DEATH:

County Carroll  
 City or town Friggsburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 15 years  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Carroll  
 City or town Friggsburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Madison Bartlett

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed  
 6.(b) Name of husband or wife Lula Mae Bartlett  
 6.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) July 6, 1867  
 8. AGE: Years 80 Months 8 Days 7 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace New York  
 (Town, county, and state)  
 10. Usual occupation Retired barber  
 11. Industry or business Own Shop  
 12. Name Andrew Bartlett  
 13. Birthplace New York  
 14. Maiden name Martha Bartlett  
 15. Birthplace New York

16. Informant Mrs. Bert Garrison  
 Address New York  
 17. Burial Date thereof 3-16-48  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory Meadow Branch Cemetery  
 Location Fr. Westminster, Md.  
 18. Funeral director C. O. Fussell Son  
 Address Fancytown, Md.  
 19. March 16 48 Maigoret R. Engle  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 13 1948 at 5:45 P  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_  
 and that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_

Immediate cause of death Carcinoma of mouth  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
 Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_  
 (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE James P. Throck Deputy Medical Examiner  
 M. D. or other \_\_\_\_\_  
 Address Westminster, Md. Date signed 3/15/48

RECEIVED

MAR 26 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. (The correct age is especially important. Physicians: please write the causes of death clearly and legibly.)

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County Carroll  
 City or town Rural Westminster  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? life  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County Carroll  
 City or town Rural Westminster  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Route 6  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Margaret Ann Beard

## 3. (b) Social Security Number

none

4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced widow  
 6. (b) Name of husband or wife John L. Beard  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) April 26, 1878  
 8. AGE: Years 69 Months 10 Days 5 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Carroll County, Md.  
 (Town, county, and state)  
 10. Usual occupation none  
 11. Industry or business

FATHER 12. Name George Freyman  
 13. Birthplace Maryland  
 MOTHER 14. Maiden name Louisa Williams  
 15. Birthplace Maryland  
 16. Informant Margaret Eisberg  
 Address Westminster, Md.

17. burial Date thereof 3/5/48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Deer Park Cemetery  
 Location Smallwood, Md.  
 18. Funeral director J. Francis Reese  
 Address Westminster, Md.  
 19. 3/4 48 L. E. Woodward  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 2, 1948 at 12:05pm

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 15-48 to Mar. 2-48  
 and that I last saw her alive on Mar. 1-48

Immediate cause of death Carcinoma of Pancreas  
2 Pancreas  
 Duration 5 years  
 Due to Diabetes Mellitus  
Hypertensive cardio vascular disease  
 Duration 10 years  
 Other conditions Carcinoma of liver secondary to pancreas  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE C. J. Billingsley M.D.  
 Address Westminster, Md. M. D. or other \_\_\_\_\_  
 Date signed 3-3-48

RECEIVED

MAR 6 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02604

Reg. Dist. No. 74

### 1. PLACE OF DEATH:

County Carroll  
City or town Sykesville  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 28 years, 11 months, 8 days  
Hospital, institution, or street address where death occurred:  
Springfield State Hospital  
How long in hospital or institution? 28 years, 11 months, 8 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Washington  
City or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. R.R. #2  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

Clara A. Betts

### 3. (b) Social Security Number

4. Sex <u>female</u>	5. Color or race <u>white</u>	6.(a) Single, married, widowed, or divorced <u>married</u>
6.(b) Name of husband or wife <u>William H. Betts</u>		
6.(c) If alive, give age <u>unknown</u> years		
7. Birth date of deceased (mo., day, yr.) <u>December 29, 1882</u>		
8. AGE: Years <u>65</u>	Months <u>2</u>	Days <u>8</u> .....hrs. ....min.

9. Birthplace Washington County, Md.  
(Town, county, and state)  
10. Usual occupation housework  
11. Industry or business

12. Name William Huntzberry  
13. Birthplace Maryland  
14. Maiden name Julia Noll  
15. Birthplace Maryland

16. Informant Hospital records  
Springfield State Hospital  
Address

17. burial Date thereof 3. 10. 48  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Rochelle  
Location Hagerstown Md.

18. Funeral director Edith V. Best  
Address Williamstown Md.

19. Mar 8 19 48 Harry Keer  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH March 8, 19 48 at 4.15a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
January 2, 19 42, to March 7 19 48  
and that I last saw her alive on March 7, 19 48

Immediate cause of death  
Coronary thrombosis DURATION 3 days

Due to arteriosclerosis and hypertensive cardio-vascular disease 15 years  
xxx diabetes mellitus 9 years

Other conditions Schizophrenia, paranoid type  
about 30 years  
(Include pregnancy within 3 months of death)

Major findings of operations  
Date of op.

Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Lune Hitchman, M.D. M. D. or other  
Springfield State Hospital Address Date signed 3-8-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 10 1948

BUREAU

RECEIVED

MAR 10 1948

BUREAU V. S.

EX. 61 - 2

*Handwritten signature*

Evidence for change  
of age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

138 02605

FILM NO. G 114 MAR 12 1948 CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll  
City or town Henryton, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 14 days  
Hospital, institution, or street address where death occurred:  
Maryland Tuberculosis Sanatorium  
How long in hospital or institution? Colored Branch, Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Balto Co  
City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Lowes Poultry Farm, Back River Rd.  
(If rural, give LOCATION) ✓

3. (a) FULL NAME

George Edward Boston

3. (b) Social Security Number

4. Sex male 5. Color or race col 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) March 8, 1896 6. (c) If alive, give age..... years

8. AGE: Years 67 Months 51 Days 11 If less than one day 24 hrs. min.

9. Birthplace Back River Rd., Baltol Md.  
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

12. Name George A. Boston

13. Birthplace Maryland

14. Maiden name Jennie Johnson

15. Birthplace Unknown

16. Informant Deceased

Address

17. Burial Date thereof 3/6/48  
(Burial, cremation, or removal, Which) (month) (day) (year)

Cemetery or crematory St. Calvary

Location Brooklyn, Ind

18. Funeral director Elroy C. Wilson

Address 1000 Brantley Ave

19. March 3 19 48 Albert R. [unclear]  
(Date rec'd by registrar) Local Deputy Registrar

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH March 3 19 48 at 6:10 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 18 19 48 to March 3 19 48  
and that I last saw him alive on March 3 19 48

Immediate cause of death Pulmonary Tuberculosis DURATION Aug 1947

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Neuber Hoffman, M.D. M.D. or other

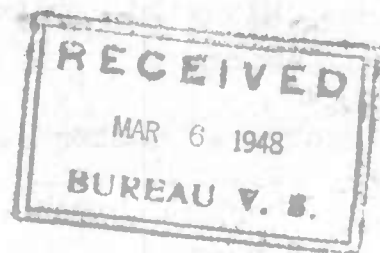
Address Henryton, Maryland Date signed 3/3/48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02606

Reg. Dist. No. 74

## 1. PLACE OF DEATH:

County Carroll  
 City or town Sykesville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 4 months, 16 days  
 Hospital, institution, or street address where death occurred:  
Springfield State Hospital  
 How long in hospital or institution? 4 months, 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County Washington  
 City or town Smithsburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) ft veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

PAUL RICHARD BOWSER

## 3. (b) Social Security Number

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced SINGLE  
 6.(b) Name of husband or wife \_\_\_\_\_  
 6.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) November 14, 1910  
 8. AGE: Years 37 Months 3 Days 17 ft less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Sabillasville, Maryland  
 (Town, county, and State)  
 10. Usual occupation Farm Hand  
 11. Industry or business Agriculture  
 12. Name Isaiah Bowser  
 13. Birthplace Smithsburg, Maryland  
 14. Maiden name Pearl Kendall  
 15. Birthplace Smithsburg, Maryland

16. Informant Record, Springfield State Hospital  
 Address Sykesville, Maryland  
 17. Burial Date thereof Mar. 4, 1948  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory Smithsburg  
 Location Smithsburg, Md.  
 18. Funeral director George B. Hoover  
 Address Smithsburg, Md.  
 19. Mar. 1 19 48 Chas. Keer  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 1 19 48 at 2:35 A.M.  
 21. I CERTIFY that death occurred on the date above stated: that I attended deceased from  
October 15 19 47 to March 1 19 48  
 and that I last saw him alive on March 1 19 48  
 Immediate cause of death \_\_\_\_\_ DURATION \_\_\_\_\_

Pulmonary Tuberculosis2/1/43

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions Schizophrenia, simple type 1/37  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
 Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Joseph H. Marshall, M.D.  
 Address Sykesville, Maryland Date signed 3/1/48

RECEIVED

MAR 3 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

## 1. PLACE OF DEATH:

County Carroll  
 City or town Henryton, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 4 month 9 days  
 Hospital, institution, or street address where death occurred:  
Maryland Tuberculosis Sanatorium  
 How long in hospital or institution? Colored Branch, Henryton

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County \_\_\_\_\_  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1103 Mc Elderly Street  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Earlene Brown

## 3. (b) Social Security Number

213- 26-7092

4. Sex female 5. Color or race col 6.(a) Single, married, widowed, or divorced Single

## 6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) August 8, 1913 6.(c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 34 Months 6 Days 28 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Charleston, S. Carolina  
 (Town, county, and state)

10. Usual occupation None

11. Industry or business \_\_\_\_\_

12. Name Joseph Brown  
 13. Birthplace S. Carolina  
 14. Maiden name Mamie Baldwin  
 15. Birthplace S. Carolina

16. Informant Deceased

Address \_\_\_\_\_

17. Burial Date thereof 3-10-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cemetery

Location St. Albans

18. Funeral director William H. Jackson  
 Address 916 Penna

19. March 7 19 48  
 (Date rec'd by registrar) Local Deputy Registrar

## MEDICAL CERTIFICATION

P.

20. DATE OF DEATH March 7 19 48 at 5:05 M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 27 19 47 to March 7 19 48  
 and that I last saw her alive on March 7 19 \_\_\_\_\_

Immediate cause of death Pulmonary Tuberculosis

DURATION

March 1  
1947

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

\_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Reuben W. Brown M.D. M. D. or other \_\_\_\_\_

Address Henryton, Maryland Date signed 3/7/48

RECEIVED

MAR 10 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02608

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

## 1. PLACE OF DEATH:

County CarrollCity or town Henryton, Maryland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 month 14 days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis SanatoriumHow long in hospital or institution? Colored Branch, Henryton

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 203 N. Parrish Street  
(If rural, give LOCATION)

(If veteran, name war)

## 3. (a) FULL NAME

George Philip Brown

## 3. (b) Social Security Number

4. Sex

male

5. Color or race

col

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

July 18, 1896

8. AGE:

Years

Months

Days

If less than one day

51728hrs.min.9. Birthplace Charlotte Hall, St. Mary's Co.  
(Town, county, and state)10. Usual occupation Porter

11. Industry or business

FATHER

12. Name Eugene Brown13. Birthplace Charlotte Hall, Md.14. Maiden name Annie Warren

MOTHER

15. Birthplace Charlotte Hall, Md.16. Informant Deceased

Address

17. Burial  
(Burial, cremation, or removal. Which?)Date thereof 3 21 48  
(month) (day) (year)Cemetery or crematory Mount AuburnLocation Baltimore18. Funeral director Mrs. Estlin P. WilliamAddress 3224 D Chandler St19. March 17 19 48  
(Date rec'd by registrar)Albert R. Southam  
Local Deputy Registrar23. SIGNATURE Robert Hoffman, M.D.

M. D. or other

Address Henryton, Maryland Date signed 3/17/48

## MEDICAL CERTIFICATION

P.M.

20. DATE OF DEATH March 17 19 48 at 5:15 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

February 3 19 48 to March 17 19 48and that I last saw him alive on March 17 19 48

Immediate cause of death

Pulmonary Tuberculosis

DURATION

June  
1947

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

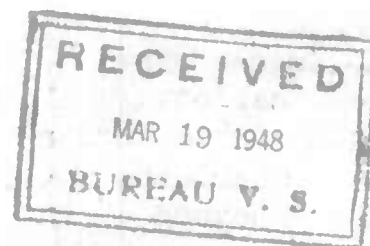
Means of injury Injured at work?

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02699

Reg. Dist. No. 74

## 1. PLACE OF DEATH:

County CarrollCity or town Henryton, Maryland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 month 25 days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis SanatoriumHow long in hospital or institution? Colored Branch, Henryton

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 108 N. Carrollton Ave.  
(If rural, give LOCATION)

(a) If veteran, name war

## 3. (a) FULL NAME

Patty Anne Catherine Campbell

## 3. (b) Social Security Number

4. Sex

female

5. Color or race

col

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

September 21, 1923

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

24519

hrs.

min.

9. Birthplace Essex County, Virginia

(Town, county, and state)

10. Usual occupation None

11. Industry or business

12. Name James Vessells13. Birthplace Unknown14. Maiden name Carrie Campbell15. Birthplace Unknown16. Informant Deceased

Address

17. Reverend  
(Burial, cremation, or removal, Which?)Date thereof 2/13/48  
(month) (day) (year)

Cemetery or crematory

Balto city mng

Location

Balto mnd

18. Funeral director

Mrs. Samuel T. Hensley

Address

578 Biddle St.19. March 1119. 48Albert R. Swankham

(Date rec'd by registrar)

Local Deputy

Registrar

23. SIGNATURE

Paulen Hoffman M.D.

M. D. or other

Address Henryton, Maryland Date signed 3/11/48

## MEDICAL CERTIFICATION

A.

20. DATE OF DEATH March 11 1948, at 8:35 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

January 15 1948, to March 11 1948.and that I last saw her alive on March 11 1948.

Immediate cause of death

Pulmonary Tuberculosis

DURATION

Jan12, 1948

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Paulen Hoffman M.D.

M. D. or other

Address Henryton, Maryland Date signed 3/11/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 15 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02610

Reg. Dist. No. 24

### 1. PLACE OF DEATH:

County Carroll  
City or town Sykesville  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 1 yr. 3 months 6 days  
Hospital, institution, or street address where death occurred:  
Springfield State Hospital  
How long in hospital or institution? 1 yr. 3 months 6 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Baltimore  
City or town - - -  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. - - -  
(If rural, give LOCATION)  
2.(a) If veteran, name war. ✓

### 3. (a) FULL NAME

Carter, Wilson Henry, Jr.

### 3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced widower  
6.(b) Name of husband or wife Rebecca Winks, dec.  
6.(c) If alive, give age - - - years  
7. Birth date of deceased (mo., day, yr.) June 3, 1862  
8. AGE: Years 85 Months 9 Days 28 If less than one day - - - hrs. - - - min.

9. Birthplace Baltimore, Maryland  
(Town, county, and state)  
10. Usual occupation Carpenter  
11. Industry or business - - -  
FATHER 12. Name John F. Carter  
13. Birthplace Carroll County, Maryland  
MOTHER 14. Maiden name Marietta Lemon  
15. Birthplace Maryland

16. Informant Records of Springfield St. Hospital  
Address Sykesville, Maryland  
17. Burial Date thereof April 3-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Druid Ridge  
Location Pikesville, Maryland  
18. Funeral director Frank H. Hurrell  
Address Pikesville, Maryland  
19. 42 88 D.W. Hedrick  
(Date filed by registrar) (month) (day) (year) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH March 31, 1948 at 12:20 p.m.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1, 1947 to March 31, 1948  
and that I last saw him alive on March 31, 1948  
Immediate cause of death Senility DURATION 5 yrs.  
Due to Terminal Bronchopneumonia  
(4/23/48 - 05.)  
Other conditions Senile psychosis 5 yrs.  
(Include pregnancy within 3 months of death)  
Major findings of operations - - - Date of op. - - -  
Autopsy results - - -  
PHYSICIAN: Please underline the cause to which death should be charged statistically.  
22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide - - - Date of - - -  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?  
23. SIGNATURE Martin Gross, M.D.  
Martin Gross, M.D. or other  
Address Sykesville, Maryland Date signed 3/31/48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 70

02611

## 1. PLACE OF DEATH:

County Carroll  
 City or town Rural - Taneytown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 19 years  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Carroll  
 City or town Rural - Taneytown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

David Diggs Clark

## 3. (b) Social Security Number

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Married</u>
6. (b) Name of husband or wife <u>Anna S Bell Clark</u>		
5. (c) If alive, give age <u>72</u> years		
7. Birth date of deceased (mo., day, yr.) <u>February 20, 1872</u>		
8. AGE:	Years	Months
<u>76</u>	<u>0</u>	<u>12</u>
Days _____ If less than one day _____ hrs. _____ min.		
9. Birthplace <u>Glades Springs, Virginia</u> (Town, county, and state)		
10. Usual occupation <u>Farmer</u>		
11. Industry or business <u>Own Farm</u>		
12. Name <u>John Breckenridge Clark</u>		
13. Birthplace <u>Virginia</u>		
14. Maiden name <u>Dorothy Williams</u>		
15. Birthplace <u>Virginia</u>		
16. Informant <u>Mrs Anna Clark</u> Address <u>Taneytown R#1, Md</u>		
17. <u>Burial</u> Date thereof <u>Mar. 6, 1948</u> (Burial, cremation, or removal. Which?) (month) (day) (year)		
Cemetery or crematory <u>Grey Creek Presbyterian</u>		
Location <u>Nr. Taneytown, Md.</u>		
18. Funeral director <u>C. O. Huss, Son</u> Address <u>Taneytown, Md.</u>		
19. <u>March 16</u> 19 <u>48</u> <u>Ethel M. Melmer</u> (Date rec'd by registrar) Registrar <u>Local</u>		

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 3 1948 at 1:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 5 1947 to Mar 3 1948 and that I last saw him alive on March 3 1948

Immediate cause of death Renal Failure

	DURATION
Due to <u>Hypertension</u>	
Due to <u>Tertiary Syphilis</u>	
Other conditions _____	
(Include pregnancy within 3 months of death)	
Major findings of operations <u>none</u>	
Antopsy results <u>none</u>	
PHYSICIAN: Please underline the cause to which death should be charged statistically.	
22. VIOLENCE: If death was due to external causes, fill in the following:	
Accident, suicide, or homicide <u>none</u>	Date of _____
Where did injury occur? _____ (City or town) (County) (State)	
Injured at home, farm, industry, public place (where?) _____	
Manner of injury <u>none</u>	Injured at work? _____
23. SIGNATURE <u>W. F. Bradley Jr.</u> Address <u>Taneytown Md.</u> Date signed <u>3/5/48</u>	

RECEIVED

MAR 9 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 82

## 1. PLACE OF DEATH:

County..... Carroll  
 City or town..... Mt. Airy  
 (If outside city or town limits, write RURAL and give nearest town)  
Life  
 How long in above place of death?.....  
 Hospital, institution, or street address where death occurred:  
 .....  
 How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... Maryland County..... Carroll  
 City or town..... Mt. Airy  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

PAUL W. CLARY

## 3. (b) Social Security Number

213-18-8772

4. Sex..... Male 5. Color or race..... White 6.(a) Single, married, widowed, or divorced..... Married  
 6.(b) Name of husband or wife..... Bessie E. Clary  
 6.(c) If alive, give age..... 45 years  
 7. Birth date of deceased (mo., day, yr.)..... Nov. 3, 1898  
 8. AGE: Year..... 49 Months..... 4 Days..... 13 If less than one day..... hrs. .... min.

Birthplace..... Carroll Co. Maryland  
 (Town, county, and state)  
 10. Usual occupation..... Janitor  
 11. Industry or business..... Mt. Airy High School  
 12. Name..... Maurice E. Clary  
 13. Birthplace..... Maryland  
 14. Maiden name..... Clara E. Smith  
 15. Birthplace..... Maryland

16. Informant..... Mrs. Bessie E. Clary  
 Address..... Mt. Airy, Md.  
 17. Burial  
 (Burial, cremation or removal. Which?) Date thereof..... 3-18-48  
 (month) (day) (year)  
 Cemetery or crematory..... Prospect  
 Location..... near Mt. Airy, Frederick Co. Md  
 18. Funeral director..... C. M. Waltz  
 Address..... Winfield, Md.

19. Mar 17 1948 Thos D. Samped  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Mar. 16 1948 at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... 19..... to..... 19.....  
 and that I last saw h..... alive on..... 19.....

Immediate cause of death.....  
Coronary Occlusion  
Pneumonia Heart disease  
 Due to.....  
 Due to.....  
 Other conditions.....  
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op. ....  
 Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?..... (City or town)..... (County)..... (State).....  
 Injured at home, farm, industry, public place (where?).....  
 Means of injury..... Injured at work?

23. SIGNATURE..... James T. Thornd Deputy Medical Examiner  
 M. D. or other.....  
 Address..... Wheaton Md Date signed..... 3-16-48

RECEIVED

MAR 19 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02613

Reg. Dist. No. 74

## 1. PLACE OF DEATH:

County Carroll  
 City or town Springfield State Hospital (Springfield)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 yr., 9 mths., 14 days  
 Hospital, institution, or street address where death occurred:  
Springfield State Hospital  
 How long in hospital or institution? 1 yr., 9 mths., 14 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind. County Baltimore City  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1116 N. Eutan St.  
 (If rural, give LOCATION) ☒

2.(a) If veteran, name war

## 3. (a) FULL NAME

Lee Ernest Connolly JR.

## 3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Elizabeth K. Connolly

7. Birth date of deceased (mo., day, yr.) June 17, 1888  
 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 59 Months 9 Days 9 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Baltimore, Ind.  
 (Town, county, and state)

10. Usual occupation None

## 11. Industry or business

12. Name James A. Connolly13. Birthplace Baltimore, Md.14. Maiden name Eleanor Kevin15. Birthplace Baltimore, Md.16. Informant M.R. LEE E. Connolly JR.Address 230 MURDOCK RD17. Burial, cremation, or removal. Which? Burial Date thereof 3/29/48

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory CATHEDRALLocation BALTO. MD.18. Funeral director Wm. T. Ticker & Sons Inc.Address BALTO. MD.19. 3/27 XP A.W. Hedrick

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 26, 1948 at 12:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 12, 1946 to March 26, 1948  
 and that I last saw him alive on March 26, 1948

Immediate cause of death Coronary thrombosis  
Arteriosclerotic heart disease DURATION 2 yrs.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Psychosis with chronic alcoholism, 8 yrs.Korsakow's syndrome

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Manner of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Joseph H. Marshall, M.D. M.D. or other \_\_\_\_\_Address Springfield State Hospital Date signed 3/26/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02614

Reg. Dist. No. 76

## 1. PLACE OF DEATH:

County Carroll  
 City or town Rural near Westminster  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
Carroll County Home  
 How long in hospital or institution? About 9 years

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll  
 City or town Westminster P.D.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Carroll County Home  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war none

## 3. (a) FULL NAME

Imothy Dwight Cragger

## 3. (b) Social Security Number

none

4. Sex M. 5. Color of face W. 6. (a) Single, married, widowed, or divorced married  
 6.(b) Name of husband or wife Ida Belle Cragger  
 6.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) July 28, 1868  
 8. AGE: Years 79 Months 7 Days 24 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Rural Retreat, Wythe Co. Va.  
 (Town, county, and state)

10. Usual occupation farmer laborer

11. Industry or business John Cragger

12. Name John Cragger

13. Birthplace Rural Retreat Va.

14. Maiden name Cosanna Orchard

15. Birthplace Wytheville Va.

16. Informant Mrs. Ida Belle Cragger

Address 287 E. Main St. Westminster Md.

17. Burial, cremation, or removal. Which? Burial Date thereof 3/24/48  
 (month) (day) (year)

Cemetery or crematory Meadow Branch Cemetery

Location Rural near Westminster Md.

18. Funeral director J. S. Myers Jr.

Address Westminster Md.

19. (Date rec'd by registrar) 19 48 Registrar [Signature]

## MEDICAL CERTIFICATION

20. DATE OF DEATH 3-22-48 at 6 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-10-48 to 3-21-48 and that I last saw him alive on 3-21-48

Immediate cause of death Pulmonary edema

Due to Cardiac decompensation

Other conditions Atrial fibrillation

Major findings of operations NO Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE [Signature]

Address Westminster Md. Date signed 3-22-48

RECEIVED

MAR 24 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

## 1. PLACE OF DEATH:

County CarrollCity or town Henryton, Maryland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 year 2 month

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis SanatoriumHow long in hospital or institution? Colored Branch, Henryton

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 218 E. Federal Street  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

William Datcher

## 3. (b) Social Security Number

218-10-5716

4. Sex

male

5. Color or race

col

6. (a) Single, married, widowed, or divorced

married6. (b) Name of husband or wife Luvenia Datcher7. Birth date of deceased (mo., day, yr.) September 18, 1890

6. (c) If alive, give age years

8. AGE: Years 55 Months 5 Days 19 If less than one day  
.....hrs. ....min.9. Birthplace Birmingham, Ala.  
(Town, county, and state)10. Usual occupation Laborer

11. Industry or business

12. Name Isaac Datcher13. Birthplace Alabama14. Maiden name Lula Baker15. Birthplace Unknown16. Informant Deceased

Address

17. Buried Date thereof 3/11/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Mt. Calvary Cem.Location Baltimore, Maryland18. Funeral director Mrs. Katie D. WallinAddress 3224 S. Chesa Dr. SE19. March 8 48 Alfred R. Swannick  
(Date rec'd by registrar) Local Deputy Registrar

## MEDICAL CERTIFICATION

A.M.

20. DATE OF DEATH March 8 19 48 at 12:30 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
January 8 19 44 to March 8 19 48  
and that I last saw him alive on March 8 19 48Immediate cause of death  
Pulmonary Tuberculosis

DURATION

Nov.1943

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Paulen Hoffman, M.D. M. D. or otherAddress Henryton, Maryland Date signed 3/8/48

RECEIVED

MAR 11 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 75

## 1. PLACE OF DEATH:

County Carroll  
 City or town Manchester Md  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 mos. 3 days  
 Hospital, institution, or street address where death occurred:  
Long View Nursing Home  
 How long in hospital or institution? 2 mos. 3 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State New Jersey County —  
 City or town Berkeley  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. —  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war —

## 3. (a) FULL NAME

James W. Davis

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Widower

6. (b) Name of husband or wife Hattie Sweigert

Received

7. Birth date of deceased (mo., day, yr.) May 7, 1860

8. AGE: Years Months Days If less than one day

87 10 23 hrs. min.

9. Birthplace Beverly N. J.

(Town, county, and state)

10. Usual occupation Flautist

11. Industry or business

12. Name unknown13. Birthplace unknown14. Maiden name unknown15. Birthplace unknown16. Informant George A. AdamsAddress 235 Lehigh Ave. Hanover Pa17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-3-48

(month) (day) (year)

Cemetery or crematory CemeteryLocation Beverly N. J.18. Funeral director James Winkler, Sr.Address Manchester Md19. March 31, 1948 Ans. H. P. S. Lermer

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 30, 1948 at 11:15 A.M.21. I CERTIFY that death occurred on the date above stated, that I attended deceased from January 27, 1948 to March 30, 1948and that I last saw him alive on March 30, 1948Immediate cause of death Cerebral Hemorrhage DURATION 3 daysDue to Arterio-Sclerotic Cerebrovascular DiseaseDue to HypertensionOther conditions —

(Include pregnancy within 3 months of death)

Major findings of operations —Autopsy results — Date of op. —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —Means of injury — Injured at work? —23. SIGNATURE Doyle E. Bush MD M. D. or otherAddress Hamstead Md Date signed 3-30-48

RECEIVED

APR 3 1948

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02617

Reg. Diat. No. 70

1. PLACE OF DEATH:

County Carroll Co  
City or town Taneytown, Md  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 12 yr  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Md County Carroll  
City or town Taneytown  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 20 Baltimore  
(If rural, give LOCATION)  
2.(a) If veteran, name war

3. (a) FULL NAME

Edward Guy Jeser

3. (b) Social Security Number

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced M

6.(b) Name of husband or wife Margaret M. Jeser

7. Birth date of deceased (mo., day, yr.) Feb 19 - 1984 6.(c) If alive, give age 65 years

8. AGE: Years 64 Months 1 Days 11 If less than one day hrs. min.

9. Birthplace Carroll Co Md  
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

12. Name Nathaniel D. Jeser

13. Birthplace Carroll Co Md

14. Maiden name Sarah Wisner

15. Birthplace Carroll Co Md

16. Informant Margaret M. Jeser

Address Taneytown Md

17. Burial Date thereof 4. 1. 48  
(Burial, cremation, or removal. When?) (month) (day) (year)

Cemetery or crematory Southern Cemetery

Location Taneytown Md

18. Funeral director Raymond F. Wright

Address Union Bridge Md

19. March 31 19 48 Mary E. Witt  
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 30 1948 at 1:45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from MARCH 29 1948 to MARCH 30 1948

and that I last saw him alive on MARCH 29 1948

Immediate cause of death ANGINA PECTORIS

DURATION

2 Days

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. M. Bernner MD M. D. or other

Address TANEYTOWN MD Date signed 3-31-48

RECEIVED

APR 7 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 76

## 1. PLACE OF DEATH:

County Carroll Co.  
 City or town Pleasant Valley near Westminister  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 24 hrs.  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Carroll  
 City or town Pleasant Valley Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. near Westminister  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Essie Jane Foutz

## 3. (b) Social Security Number

4. Sex f. 5. Color or race W. 6.(a) Single, married, widowed, or divorced widowed

6.(b) Name of husband or wife Charles R Foutz  
 6.(c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Feb. 10, 1877

8. AGE: Years 71 Months 1 Days 18 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Christiansburg, West Co. Va.  
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name William Atkinson

13. Birthplace Virginia

14. Maiden name Parker

15. Birthplace Virginia

16. Informant Carl B. Foutz

Address Westminister, Md. R.D.

17. Removal Date thereof 3/31/48  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory South family Cemetery

Location Stewartsville, Bedford Co. Va.

18. Funeral director J. S. Myers, Jr.

Address Westminister, Md.

19. 3/29 1948 Registrar

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 28 1948 at 6 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1945 to Mar 28 1948  
 and that I last saw her alive on Mar. 25 1948

Immediate cause of death, Carcinoma of uterus

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE E. Reesel Wilkens M. D. or other \_\_\_\_\_

Address Westminister Date signed 3/28/48

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

RECEIVED

CERTIFICATE OF DEATH

RECEIVED

MAR 31 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02619

Evidence for change of birthdate shown on:

FILM No. G 114 MAR 31 1948

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

## 1. PLACE OF DEATH:

County Carroll  
City or town Henryton, Maryland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 months 19 days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis SanatoriumHow long in hospital or institution? Colored Branch, Henryton

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County TalbotCity or town Oxford  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3.(a) FULL NAME

Victoria Frances Greene

## 3.(b) Social Security Number

## 4. Sex

female

## 5. Color or race

col

## 6.(a) Single, married, widowed, or divorced

Married6.(b) Name of husband or wife Charles E. Greene

## 7. Birth date of

deceased (mo., day, yr.)

March 12, 1913 19036.(c) If alive, give age 46 years

## 8. AGE:

Years

Months

Days

If less than one day

45012

hrs.

min.

9. Birthplace Oxford, Maryland  
(Town, county, and state)10. Usual occupation Housewife

## 11. Industry or business

12. Name Greenby Brooks13. Birthplace Maryland14. Maiden name Henrietta Sherwood15. Birthplace Maryland16. Informant Deceased

Address

17. Burial Date thereof March 19/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory CemeteryLocation Oxford and18. Funeral director Selvit BoyneumAddress Cambridge Ford19. March 24 19 48  
(Date rec'd by registrar)Local Deputy

Registrar

## MEDICAL CERTIFICATION

A.

20. DATE OF DEATH March 24 19 48, at 7:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 5 19 48, to March 24 19 48and that I last saw her alive on March 24 19 48

Immediate cause of death

Pulmonary Tuberculosis

DURATION

July  
1947

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

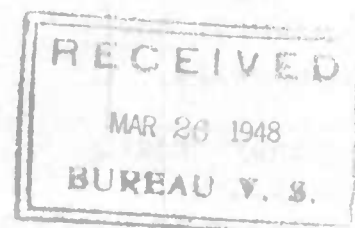
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Paulen Hoffman, M.D.  
M. D. or otherAddress Henryton, Maryland Date signed 3/24/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02620

Reg. Dist. No. 74

## 1. PLACE OF DEATH:

County Carroll  
 City or town Springfield State Hospital  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 7 mos., 24 days  
 Hospital, institution, or street address where death occurred:  
Springfield State Hospital  
 How long in hospital or institution? 7 mos., 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Md. County Carroll  
 City or town Taneytown, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3.(a) FULL NAME

Josephine Crass Hull

## 3.(b) Social Security Number

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife R

7. Birth date of deceased (mo., day, yr.) June 29, 1866 6.(c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 81 Months 8 Days 17 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Adams County, Pa.  
 (Town, county, and state)

10. Usual occupation Housewife

## 11. Industry or business

12. Name George C. Crass

13. Birthplace Germany

14. Maiden name Catherine F. Leigh

15. Birthplace Pennsylvania

16. Informant Hospital records

Address \_\_\_\_\_

17. Burial Date thereof May 20, 1948  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory St. John's Cemetery

Location Westminster, Md.

18. Funeral director C. O. Suss & Son

Address Taneytown, Md.

19. May 18, 1948 Harry H. Her  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 17, 1948 at 7:45 P. M.

21. I CERTIFY that death occurred on the date above cited; that I attended deceased from July 22, 1947 to March 17, 1948  
 and that I last saw him/her alive on March 17, 1948

Immediate cause of death Generalized arteriosclerosis  
chronic myocarditis

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Senile psychosis 18 mos.

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

\_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Manner of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Joseph H. Marshall, M.D.

Address Springfield State Hospital Date signed 3/17/48

3

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 76

## 1. PLACE OF DEATH:

County Carroll  
 City or town Westminster  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 years  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County Carroll  
 City or town Westminster  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 100 Liberty  
 (If rural, give LOCATION)

2.(a) if veteran, name war

## 3. (a) FULL NAME

William Thomas Harris

## 3. (b) Social Security Number

none

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced single

## 6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) march 28 - 1873 6.(c) If alive, give age..... years

8. AGE: Years 74 Months 5 Days - It less than one day..... hrs. min.

9. Birthplace Carroll Co. Md.  
 (Town, county, and state)

10. Usual occupation none

## 11. Industry or business

FATHER 12. Name Samuel Harris  
 13. Birthplace Carroll Co. Md.  
 MOTHER 14. Maiden name Sarah M. Coffey  
 15. Birthplace Carroll Co. Md.

16. Informant Mrs. Alma M. Coffey  
 Address Liberty St. Westminster, Md.

17. Burial Date thereof April 1, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory S. T. Johns Cemetery  
 Location Westminster, Md.

18. Funeral director W. Bankard Don  
 Address Westminster, Md.

19. 330 48 19. 48  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH march 28 1948 at 5:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from march 28 1948 to march 28 1948 and that I last saw him alive on march 28 1948

Immediate cause of death Coronary Occlusion DURATION Instant

Due to arterio sclerosis  
General & myocardial  
degeneration

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

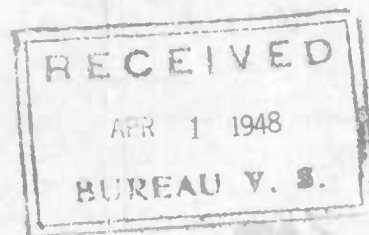
23. SIGNATURE William Percher M. D. or other

Address Westminster, Md. Date signed 3/29/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02622

Reg. Dist. No. 75

## 1. PLACE OF DEATH:

County CarrollCity or town Manchester Md Rural  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 32 yearsHospital, institution, or street address where death occurred: old York Road

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CarrollCity or town Manchester Md Rural  
(If outside city or town limits, write RURAL and give nearest town)Street No. old York Road  
(If rural, give LOCATION)

2.(a) if veteran, name war

## 3. (a) FULL NAME

Sarah ANN Herbst

## 3. (b) Social Security Number

4. Sex Female5. Color or race white6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Franklin Herbst6. (c) If alive, give age 73 years7. Birth date of deceased (mo., day, yr.) August 31, 18748. AGE: Years 73 Months 6 Days 14 If less than one day hrs. min.9. Birthplace Hampstead Md  
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Home12. Name George Miller13. Birthplace Maryland14. Maiden name Annie Stop15. Birthplace Maryland16. Informant Franklin HerbstAddress Manchester Maryland17. Buried Date thereof May 16/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory ManchesterLocation Carroll Co Md18. Funeral director Edw C RipstonAddress Hampstead Md19. March 14 1948 Mrs W P Sanner  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 14 1948 at 3:40 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 18 1940 to March 14 1948 and that I last saw him alive on March 7 1948Immediate cause of death Coronary Occlusion DURATION SuddenDue to Chronic Myocarditis ?Due to Arterio Sclerotic Cardio VascularOther conditions Union

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

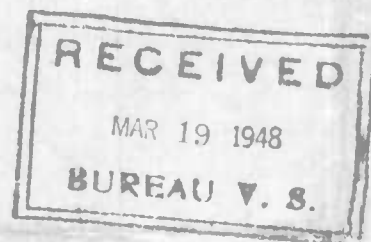
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Joseph E Bush MD M. D. or otherAddress Hampstead Md Date signed 3-14-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

MAR 19 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

## 1. PLACE OF DEATH:

County Carroll  
 City or town Rural Sykesville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 6 yrs., 4 mo., 6 days  
 Hospital, institution, or street address where death occurred:  
Springfield State Hospital  
 How long in hospital or institution? 6 yrs., 4 mo., 6 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore Co.  
 City or town Monkton  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. ?  
 (If rural, give LOCATION) ✓  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

HILD, Charles Wesley

## 3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed  
 6. (b) Name of husband or wife ? 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) 9-16-1866  
 8. AGE: Years 81 Months 5 Days 23 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Harford Co., Md.  
 (Town, county, and state)  
 10. Usual occupation Farmer  
 11. Industry or business  
 FATHER 12. Name John Wesley Hild  
 13. Birthplace Harford Co., Md.  
 MOTHER 14. Maiden name Clara Sutton  
 15. Birthplace Pa.

16. Informant Records of Springfield State Hospital  
 Address Sykesville, Md.

17. Burial Date thereof Mar. 13 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Wesley Chapel Cem.  
Balto. Co., Md.  
 Location

18. Funeral director John Burns' Sons  
 Address Towson, Maryland

19. Mar 12 48 Q. W. Hedrick  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 10 1948 at 4, 20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
September 1 1947 to March 10 1948  
 and that I last saw him alive on March 10 1948

Immediate cause of death Arteriosclerosis DURATION 18 yrs

Due to

Due to

Other conditions Manic depressive psychosis 23 yrs

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Martin Gross, M.D. M. D. or otherAddress Sykesville, Md. Date signed 3-10-48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02624

Reg. Dist. No. 81

## 1. PLACE OF DEATH:

County CarrollCity or town Union Bridge  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CarrollCity or town Union Bridge  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

malewhitemarried

6. (b) Name of husband or wife

Heights Hollenbaugh

7. Birth date of

deceased (mo., day, yr.)

August 20 - 1869

6. (c) If alive, give age \_\_\_\_\_ years

8. AGE:

Years

Months

Days

If less than one day

78624

hrs.

min.

9. Birthplace

Carroll County, Md.

(Town, county, and state)

10. Usual occupation

Labourer

11. Industry or business

MOTHER

12. Name

Emmanuel Hollenbaugh

13. Birthplace

Maryland

14. Maiden name

Catherine Hull

15. Birthplace

Maryland

16. Informant

Mrs. Heights Hollenbaugh

Address

Union Bridge, Md.

17. Burial

burial, cremation, or removal. Which?

Date thereof

May 17 - 48

Cemetery or crematory

Mountain View Cemetery

Location

Union Bridge, Md.

18. Funeral director

W. H. Harkins & Sons

Address

Union Bridge & New Windsor, Md.

19. Date rec'd by registrar

March 15 - 1948

Registrar

## 3. (b) Social Security Number

220-18-1484

## MEDICAL CERTIFICATION

20. DATE OF DEATH

March 15 - 1948 at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 6 - 1947 to March 15 - 1948and that I last saw him alive on March 14 - 1948

Immediate cause of death

Chronic myocarditis

DURATION

Due to

Due to

arterio-sclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury

Injured at work?

23. SIGNATURE

J. H. Harkins

M. D. or other

Address

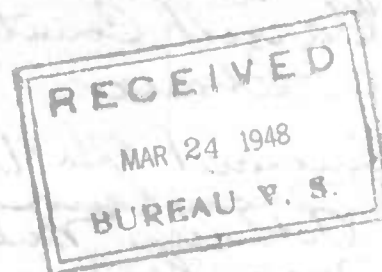
Union BridgeDate signed 3/15/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02625

Reg. Dist. No. 74

### 1. PLACE OF DEATH:

County Carroll  
City or town Eldersburg  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 4 yrs  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State md County Carroll  
City or town Eldersburg  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Superiorville R.F.D.  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

Elmer Ellsworth Hood

### 3. (b) Social Security Number

None

4. Sex M 5. Color or race A 6.(a) Single, married, widowed, or divorced Widowed  
6.(b) Name of husband or wife Cora E.  
6.(c) If alive, give age \_\_\_\_\_ years  
7. Birth date of deceased (mo., day, yr.) Oct. 21, 1861  
8. AGE: Years 86 Months 5 Days 9 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

### MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 30 1948 at 7 P.  
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Mar. 27 1948 to Mar 30 1948  
and that I last saw him alive on Mar. 27 1948

Immediate cause of death Coronary Vascular Disease DURATION

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
Autopsy results \_\_\_\_\_  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
Means of injury \_\_\_\_\_ Injured at work?

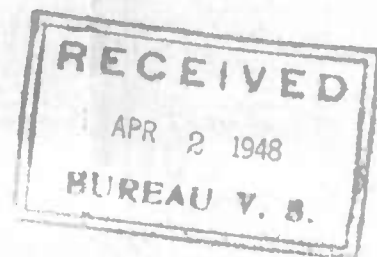
23. SIGNATURE Wm. E. Martin M. D. or other  
Randalltown Address \_\_\_\_\_ Date signed 3/31/48

9. Birthplace md (Town, county, and state)  
10. Usual occupation Farmer, Retired  
11. Industry or business \_\_\_\_\_  
12. Name Sylvester Hood  
13. Birthplace md  
14. Maiden name Margaret A. Brashear  
15. Birthplace md  
16. Informant Chester E. Hood  
Address Superiorville md  
17. Burial Date thereof Apr. 2, 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)  
Cemetery or crematory Morgan Chapel  
Location Hoodbine, md  
18. Funeral director Nancy Keen  
Address Superiorville md  
19. Apr. 1 1948 Nancy Keen  
(Date rec'd by registrar) Registrar

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02626

## CERTIFICATE OF DEATH

Reg. Dist. No. 81

## 1. PLACE OF DEATH:

County Carroll CoCity or town Near Union Bridge, Md  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 yr

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CarrollCity or town Near Union Bridge  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Charles Quinton Jones

## 3. (b) Social Security Number

118-09-2536

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Fannie Davis Jones

7. Birth date of deceased (mo., day, yr.)

Mar 15- 18936. (c) If alive, give age 63 years

8. AGE:

Years 64Months 9Days 22

If less than one day

hrs. \_\_\_\_\_ min.

9. Birthplace

Philadelphia Pa.  
(Town, county, and state)

10. Usual occupation

Engineer

11. Industry or business

MOTHER FATHER

12. Name

Charles Jones

13. Birthplace

Pa.

14. Maiden name

Unknown

15. Birthplace

"

16. Informant

Fannie D. Jones

Address

Union Bridge, Md

17.

(Burial, cremation, or removal, Which?)

Buried

Date thereof

3-10-48  
(month) (day) (year)

Cemetery or crematory

St. Mary's

Location

Uniontown

18. Funeral director

Raymond F. Knight

Address

Union Bridge, Md

19.

(Date rec'd by registrar)

March 9 1948

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 7 1948 at 1 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 21 1948 to Mar 7 1948  
and that I last saw him alive on March 6 1948

Immediate cause of death

Cerebral Hemorrhage

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. N. Legg

M. D. or other

Address

Union BridgeDate signed 3-8-48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 11 1948

BUREAU V. 8.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

4800 02627

Reg. Dist. No. 74

## 1. PLACE OF DEATH:

County Carroll  
 City or town Henryton, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 4 month 8 days  
 Hospital, institution, or street address where death occurred:  
Maryland Tuberculosis Sanatorium  
 How long in hospital or institution? Colored Branch, Henryton

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Dorchester  
 City or town Rhodesdale  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Route 1 Box 45  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Hattie Jane Jones

## 3. (b) Social Security Number

4. Sex female 5. Color or race col 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife John Frances Jones  
 7. Birth date of deceased (mo., day, yr.) September 12, 1904  
 6. (c) If alive, give age years  
 8. AGE: Years 43 Months 5 Days 25 If less than one day  
hrs. min.

9. Birthplace Dorchester Co. Maryland  
 (Town, county, and state)  
 10. Usual occupation Canning Factory  
 11. Industry or business

12. Name Henry Stanley  
 13. Birthplace Maryland  
 14. Maiden name Henrietta Thompson  
 15. Birthplace Maryland

18. Informant Deceased

Address

17. Burial Date thereof 3-11-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Thompson Cem.  
 Location Dorchester County, Md.

18. Funeral director J. J. Thompson  
 Address Edwardsburg, Maryland

19. March 8 1948  
 (Date rec'd by registrar) Local Deputy Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 8 1948 at 1:30 M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
October 29 1947 to March 8 1948  
 and that I last saw him/her alive on March 8 1948

Immediate cause of death Pulmonary Tuberculosis  
 DURATION April 1947

Due to  
 Due to

Other conditions Carcinoma of the cervix Sept. 2, 1947  
 (Include pregnancy within 3 months of death)

Major findings of operations  
 Date of op.

Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Date of  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE Neuben Hoffman, M.D. M. D. or other  
Henryton, Maryland Date signed 3/8/48

**RECEIVED**

**MAR 10 1948**

**BUREAU V. S.**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02628

Reg. Dist. No. 74

## 1. PLACE OF DEATH:

County Carroll  
 City or town Lylesville  
 If outside city or town limits, write RURAL and give nearest town  
 How long in above place of death? 2 yrs 2 mo 2 da  
 Hospital, institution, or street address where death occurred  
Springfield State Hospital  
 How long in hospital or institution? 2 yrs 2 mo 2 da

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Montgomery  
 City or town Gaithersburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Emma Beatha Kelly

## 3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife \_\_\_\_\_

7. Birth date of deceased (mo., day, yr.) Dec 28 - 1871 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 76 Months 2 Days 15 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Rockville Ind.  
 (Town, county, and state)  
Teacher

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name Daniel Kelly13. Birthplace Ireland14. Maiden name Mary Jane Hutchinson15. Birthplace Pap16. Informant Mr. Gusie PerryAddress Roanoke Va17. Removal Removal Date thereof Mar. 14, 1948

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory \_\_\_\_\_

Location Gaithersburg, Md.18. Funeral director E C GaitnerAddress Gaithersburg, Md.19. Mar. 16 1948 Harry Keer

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 16 1948 at 10-20 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 22 1945 to Mar 16 1948and that I last saw him/her alive on Mar 16 1948

Immediate cause of death \_\_\_\_\_ DURATION

Cerebral Hemorrhage 2 wks

Due to \_\_\_\_\_

Sub. Arterio Sclerosis 15 yrs

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE J J Wartin MD Mr. D. DeathAddress Lylesville Ind signed 3/16/48

RECEIVED

MAR 18 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02629

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

### 1. PLACE OF DEATH:

County Carroll  
City or town Henryton, Maryland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch, Henryton

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 129 S. Bond Street

(If rural, give LOCATION)

2.(a) If veteran, name war I

### 3. (a) FULL NAME

Harry Austin Lee

### 3. (b) Social Security Number

217-07-5275

4. Sex male 5. Color or race col 6. (a) Single, married, widowed, or divorced Separated

6. (b) Name of husband or wife Evelyn Collins Lee

7. Birth date of deceased (mo., day, yr.) October 5, 1893

8. AGE: Years 54 Months 4 Days 26 It less than one day hrs. min.

9. Birthplace Richmond County, Virginia  
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

12. Name Henry Lee

13. Birthplace Richmond Co., Virginia

14. Maiden name Betty Alice Johnson

15. Birthplace Richmond Co., Virginia

16. Informant Deceased

Address Personal

17. Personal Date thereof March 6<sup>th</sup> 48  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Baltimore City League

Location Baltimore, Md.

18. Funeral director Mr. Francis A. Henry

Address 578 W. Biddle St.

19. March 2 19 48 Albert R. Swann

(Date rec'd by registrar) Local Deputy Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH March 2 19 48 at 7 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 11 19 48 to March 2 19 48

and that I last saw him alive on March 2 19 48

Immediate cause of death Pulmonary Tuberculosis

DURATION

Sept. 1947

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home: farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert Hoffman, M.D. M. D. or other

Address Henryton, Maryland Date signed 3/2/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 8 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02630

Reg. Dist. No. 74

### 1. PLACE OF DEATH:

County... Carroll  
City or town... Springfield  
How long in above place of death? 13 yrs 1 mo 13 da  
Hospital, institution, or street address where death occurred: Springfield State Hospital  
How long in hospital or institution? 15 yrs 1 mo 15 da

### 2. USUAL RESIDENCE (HOME) OF DECEASED

(For newborn infants give residence of mother)  
State... Ind. County... Washington  
City or town... Hagerstown  
Street No...  
(If rural, give LOCATION)

### 3. (a) FULL NAME

Hattie Leggett

### 3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Oct 29 1864 6. (c) If alive, give age... years

8. AGE: Year 83 Months 4 Days 5 If less than one day... hrs. min.

9. Birthplace... Washington  
(Town, county, and state)

10. Usual occupation... Housekeeper

11. Industry or business

12. Name... John Leggett

13. Birthplace... Washington

14. Maiden name... Elyse Wolf

15. Birthplace... Washington

16. Informant... Mrs. Jannet Carlwright

Address... 4801 Wisconsin Ave NW Wash DC

17. Burial Date thereof 3-8-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Bone Hill Cemetery

Location... Hagerstown Md.

18. Funeral director... Scott J. Minnich

Address... Hagerstown Md.

19. Mar 5 1948 Obituary News  
(Date rec'd by registrar)

Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH... March 5 1948 at 5-25 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 19th 1933 to March 5 1948  
and that I last saw him alive on Mar 5th 1948

Immediate cause of death... Chronic Myocarditis 10 yrs  
Due to... Cerebral Sclerosis 13 yrs  
Due to... Hypertension  
Other conditions...

(Include pregnancy within 3 months of death)

Major findings of operations... Date of op...

Autopsy results...  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... W. J. Gaster

Address... Springfield Ind Date signed 3/5/48

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

**RECEIVED**

MAR 8 1948

**BUREAU V. S.**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

RECEIVED

MAR 26 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02632

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

### 1. PLACE OF DEATH:

County Carroll  
City or town Henryton, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 7 Months, 18 Days  
Hospital, institution, or street address where death occurred:  
Maryland Tuberculosis Sanatorium  
Colored Branch  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Dorchester  
City or town Church Creek  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)  
2.(a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

EDWARD MEEKINS

### 3. (b) Social Security Number

214-18-4109

#### 4. Sex

Male

#### 5. Color or race

Colored

#### 6. (a) Single, married, widowed, or divorced

Single

#### 6. (b) Name of husband or wife

#### 7. Birth date of deceased (mo., day, yr.)

July 4, 1920

#### 6. (c) If alive, give age \_\_\_\_\_ years

#### 8. AGE:

Years

Months

Days

If less than one day

27

8

25

hrs.

min.

#### 9. Birthplace

Church Creek, Dorchester, Md.

(Town, county, and state)

#### 10. Usual occupation

Farm Helper

#### 11. Industry or business

FATHER  
MOTHER

#### 12. Name

Charles Meekins

#### 13. Birthplace

Maryland

#### 14. Maiden name

Agnes Chester

#### 15. Birthplace

Maryland

#### 16. Informant

Deceased

#### Address

#### 17.

(Burial, cremation, or funeral. Which?)

#### Date thereof

(month) (day) (year)

#### Cemetery or crematory

#### Location

#### 18. Funeral director

#### Address

#### 19.

(Date rec'd by registrar)

March 29,

1948

Local Deputy Registrar

Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH March 29, 1948 at 12: Noon

#### 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 11, 1947, to March 29, 1948

and that I last saw him alive on March 29, 1948

#### Immediate cause of death

Pulmonary Tuberculosis

#### DURATION

Sept.

1946

#### Due to

#### Due to

#### Other conditions

(Include pregnancy within 3 months of death)

#### Major findings of operations

Date of op.

#### Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

#### 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

#### Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

#### Means of injury

Injured at work?

#### 23. SIGNATURE

Heaven Hoffman, M.D.

M. D. or other

#### Address

Henryton, Md.

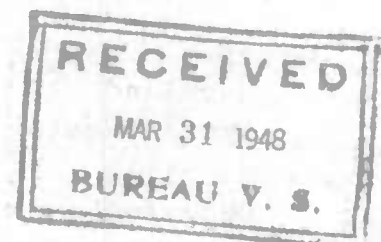
Date signed 3-29-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02633

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

## 1. PLACE OF DEATH:

County Carroll  
 City or town Henryton, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 month 21 days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium  
Colored Branch, Henryton

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Brooklyn  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. Box 342 Route #9  
 (If rural, give LOCATION)

2(a) If veteran, name war

## 3. (a) FULL NAME

Spotswood Alphonso Minor

## 3. (b) Social Security Number

212-18-3815

## 4. Sex

male

## 5. Color or race

col

## 6. (a) Single, married, widowed, or divorced

Divorced

## 6. (b) Name of husband or wife

## 7. Birth date of deceased (mo., day, yr.)

August 18, 1919

## 6. (c) If alive, give age years

## 8. AGE:

Years

Months

Days

If less than one day

28624

hrs.

min.

## 9. Birthplace

Spotwood, Virginia  
(Town, county, and state)

## 10. Usual occupation

Insurance Agent

## 11. Industry or business

FATHER  
 MOTHER

## 12. Name

Lyke Minor

## 13. Birthplace

Virginia

## 14. Maiden name

Ruth Smith

## 15. Birthplace

Virginia

## 16. Informant

Deceased

## Address

## 17. Burial, cremation, or removal, which?

Funeral

## Date thereat

March 16, 1948

## Cemetery or crematory

## Location

## 18. Funeral director

## Address

## 19. Date rec'd by registrar

March 13, 1948Local Deputy

Registrar

## 23. SIGNATURE

Henryton, Maryland

M. D. or other

Date signed 3/13/48

## MEDICAL CERTIFICATION

A.

20. DATE OF DEATH March 13, 1948 at 2:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 21, 1948 to March 13, 1948and that I last saw him alive on March 13, 1948

Immediate cause of death

Pulmonary Tuberculosis

## DURATION

Jan. 12, 1941

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. FORCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Henryton, Maryland

M. D. or other

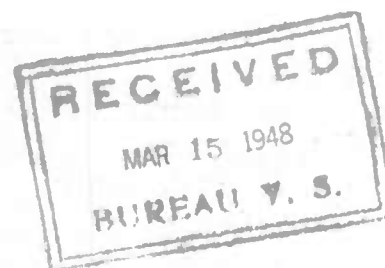
Date signed 3/13/48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02634

Reg. Dist. No. 74

## 1. PLACE OF DEATH:

County Carroll  
 City or town Sykesville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 17 years 1 month 19 days  
 Hospital, institution, or street address where death occurred:  
Springfield State Hospital  
 How long in hospital or institution? 17 years 1 month 19 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Frederick  
 City or town Frederick  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Dorsey Murdoch

## 3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) August 13, 1874

8. AGE: Years 73 Months 7 Days 8 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Frederick County, Maryland  
 (Town, county, and state)

10. Usual occupation Farm laborer

11. Industry or business \_\_\_\_\_

FATHER 12. Name Richard H. Murdoch

13. Birthplace Maryland

MOTHER 14. Maiden name Mary E. Mediary

15. Birthplace Maryland

16. Informant Records - Springfield St. Hospital

Address Sykesville, Maryland

17. Burial Date thereof 3/26/48  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Springfield Hosp. Cem.

Location Sykesville, Md.

18. Funeral director C. H. Evers

Address Sykesville, Md.

19. Mar 26 19 48 C. H. Evers  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 22 19 48 at 2:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1 19 47 to March 21 19 48  
 and that I last saw him alive on March 21 19 48

Immediate cause of death Heart failure DURATION 3 days  
Mitral insufficiency 15 years

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Cerebral arteriosclerosis 15 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

\_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Martin Gross, M.D.

Martin Gross, M.D. M. D. or other

Address Sykesville, Maryland Date signed 3/22/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

T

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**RECEIVED**

MAR 29 1948

**BUREAU V. S.**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02635

93d

Reg. Dist. No. 74

## 1. PLACE OF DEATH:

County CarrollCity or town North Branch  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 30 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County CarrollCity or town North Branch  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Columbus Parker

## 3. (b) Social Security Number

4. Sex M 5. Color or race A 6.(a) Single, married, widowed, or divorcedWidowed6.(b) Name of husband or wife Cora A.7. Birth date of deceased (mo., day, yr.) Mar. 22, 1867 6.(c) If alive, give age \_\_\_\_\_ years8. AGE: Years 80 Months 4 Days 1 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Md.  
(Town, county, and state)10. Usual occupation Farmer, Retired

11. Industry or business

12. Name Columbus Parker13. Birthplace Md.14. Maiden name Labitha Dell15. Birthplace Md.16. Informant James N. ParkerAddress Sykesville Md.17. Burial Date thereof Mar 25, 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Old OaklandLocation Oakland Md.18. Funeral director Harry KeerAddress Sykesville, Md.19. Mar. 24 19 48 Harry Keer  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 23 19 48 at 5 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Mar. 1st 19 48 to Mar. 23, 19 48and that I last saw him alive on Mar. 22, 19 48Immediate cause of death Coronary Vascular Disease

DURATION

?

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Em. E. Martin M. D. or otherAddress Pandalltown Md Date signed 3/29/48

RECEIVED

MAR 25 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02636

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

## 1. PLACE OF DEATH:

County Carroll  
 City or town Henryton, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 8 Months, 20 Days  
 Hospital, institution, or street address where death occurred:  
Maryland Tuberculosis Sanatorium  
 How long in hospital or institution? Colored Branch

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 144 W. Cross Street  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

JOSEPH PARKER

## 3. (b) Social Security Number

220-01-1859

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Widowed  
 6. (b) Name of husband or wife  
 6. (c) If alive, give age years  
 7. Birth date of deceased (mo., day, yr.) May 25, 1886  
 8. AGE: Years 61 Months 10 Days 2 It less than one day  
 hrs. min.

9. Birthplace Calvert County, Maryland  
 (Town, county, and state)

10. Usual occupation Factory Work

## 11. Industry or business

12. Name Joseph Parker

13. Birthplace Maryland

14. Maiden name Annie Reed

15. Birthplace Maryland

16. Informant Decedent

Address

17. Burial Date thereof 3 31 48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Calvary Cemetery

Location Anne Arundel

19. Funeral director Walter B. Spriggs

Address 139 W. Hamburg St.

19. Mar. 27, 19 48 Albert R. Swann  
 (Date rec'd by registrar) Local Deputy Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 27, 19 48 at 10: P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
July 7, 19 47 to March 27, 19 48  
 and that I last saw him alive on March 27, 19 48

Immediate cause of death  
Pulmonary Tuberculosis  
 DURATION  
May 1946

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert Hoffman, M. D. M. D. or other

Address Henryton, Md. Date signed 3-27-48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**RECEIVED**

MAR 30 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02637

Reg. Dist. No. 74

### 1. PLACE OF DEATH:

County Carroll  
City or town Sykesville, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 25 yrs. 6 mos. 17 days  
Hospital, institution, or street address where death occurred:  
Springfield State Hospital  
How long in hospital or institution? 25 yrs. 6 mos. 17 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Prince George's  
City or town Capital Heights, Md.  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)  
2.(a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

Joseph Pavlousek

### 3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married  
6.(b) Name of deceased or wife Mrs. Jaroslava Pavlousek  
6.(c) If alive, give age unkn. years  
7. Birth date of deceased (mo., day, yr.) 1883 (?)  
8. AGE: Years 65 Months ? Days ? It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Moravia  
(Town, county, and state)

10. Usual occupation Butcher

### 11. Industry or business

FATHER 12. Name Frank Pavlousek  
13. Birthplace Moravia  
MOTHER 14. Maiden name Josephine ?  
15. Birthplace Moravia

16. Informant Records of the Springfield State Hospital, Sykesville, Md.

17. Burial Date thereof Mar 13 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Springfield Hospital Cem.  
Sykesville, Md.  
Location

18. Funeral director Harry Keer  
Address Sykesville, Md.

19. Mar 13 19 48 Harry Keer  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH March 7 19 48 at 4:15 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1 19 47 to March 7 19 48  
and that I last saw him March 7 19 48

Immediate cause of death Coronary thrombosis  
DURATION ?

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions Dementia Praecox  
(Include pregnancy within 8 months of death) 31 yrs.

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results Coronary thrombosis, arteriosclerosis  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

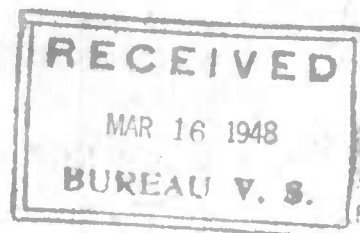
23. SIGNATURE Martin Gross, M.D.  
Address Sykesville, Maryland Date signed 3/8/48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02638

Reg. Dist. No. 76

## 1. PLACE OF DEATH:

County Carroll  
 City or town Westminster  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 years  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll  
 City or town Westminster  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 288 E. Green  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Nathan Grant Poole

## 3. (b) Social Security Number

3000

## 4. Sex

M

## 5. Color or race

W

## 6. (a) Single, married, widowed, or divorced

Widowed

## 6. (b) Name of husband or wife

1st Mollie Phillips  
2nd Annie Valentine

## 6. (c) If alive, give age..... years

## 7. Birth date of deceased (mo., day, yr.)

Nov. 22 - 1868

## 8. AGE:

79

Months

8

Days

If less than one day

hrs.min.

## 9. Birthplace

Carroll Co. Md.  
 (Town, county, and state)

## 10. Usual occupation

Farmer ret.

## 11. Industry or business

FATHER

12. Name

John Poole

13. Birthplace

Carroll Co. Md.

MOTHER

14. Maiden name

Not known

15. Birthplace

## 16. Informant

Emory G. Poole

Address

Balt. 27. Md.

## 17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

March 24, 1948  
(month) (day) (year)

Cemetery or crematory

Providence Methodist

Location

Sanger, Md.

## 18. Funeral director

H. Bankard Hon

Address

Westminster, Md.

## 19. (Date rec'd by registrar)

3/23/48

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Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 22 1948, at 12:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 18 1948 to March 22 1948and that I last saw him alive on March 21 1948Immediate cause of death Pneumonia, later 4 DURATIONarterio-sclerotic changesmyocardial degeneration 4 yrs.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur? .....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) .....

Means of injury .....

Injured at work?

23. SIGNATURE.....

M, D, or other

Address.....

Date signed 3/23/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02639

Reg. Dist. No. 74

## 1. PLACE OF DEATH:

County Carroll  
 City or town Henryton, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 7 months 6 days  
 Hospital, institution, or street address where death occurred:  
Maryland Tuberculosis Sanatorium  
 How long in hospital or institution? Colored Branch, Henryton

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County \_\_\_\_\_  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1405 Argyle Ave.  
 (If rural, give LOCATION) ✓  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Mazie Elizabeth Reed

## 3. (b) Social Security Number

214-14-3821

## 4. Sex

female

## 5. Color or race

col

## 6. (a) Single, married, widowed, or divorced

Single

## 6. (b) Name of husband or wife

## 7. Birth date of deceased (mo., day, yr.)

November 11, 1920

## 6. (c) If alive, give age \_\_\_\_\_ years

## 8. AGE:

Years

Months

Days

If less than one day

2747

hrs.

min.

## 9. Birthplace

Baltimore, Maryland  
(Town, county, and state)

## 10. Usual occupation

Kitchen Helper

## 11. Industry or business

FATHER  
MOTHER

## 12. Name

John Reed

## 13. Birthplace

Unknown

## 14. Maiden name

Margaret Reed

## 15. Birthplace

Virginia

## 16. Informant

Deceased

## Address

## 17.

Burial  
(Burial, cremation, or removal. Which?)

## Date thereof

3/16/48  
(month) (day) (year)

## Cemetery or crematory

First Auburn

## Location

## 18. Funeral director

Wm Jackson

## Address

916 Pennsylvania Ave

## 19.

March 11  
(Date rec'd by registrar)19. 48Albert R. Swandlow  
Local Deputy Registrar

## 23. SIGNATURE

Neuben Hoffman, M.D.  
M. D. or other  
Address Henryton, Maryland Date signed 3/11/48

## MEDICAL CERTIFICATION

A.

## 20. DATE OF DEATH

March 1119. 48at 8:15 M

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 519. 47March 1119. 48and that I last saw her alive on March 11 19. 48

## Immediate cause of death

Pulmonary Tuberculosis

## DURATION

April1, 1947

## Due to

## Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

**RECEIVED**

MAR 18 1948

**BUREAU V. S.**

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

02640

76

### 1. PLACE OF DEATH

County Carroll  
City or town Westminster  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 34 years  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Carroll  
City or town Westminster  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 15 Willis Street  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

Mary Louise Reese

### 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
6.(b) Name of husband or wife J. Francis Reese  
6.(c) If alive, give age 54 years  
7. Birth date of deceased (mo., day, yr.) July 15 1894  
8. AGE: Years 53 Months 8 Days 3 If less than one day hrs. min.

9. Birthplace Pocomoke City, Maryland  
(Town, county, and state)  
10. Usual occupation Housewife

### 11. Industry or business

12. Name Wilmer C. Gullette  
13. Birthplace Maryland  
14. Maiden name Mary L. Landing  
15. Birthplace Maryland

16. Informant J. Francis Reese  
Address Westminster, Md.

17. Burial Date thereof Mar. 21, 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)  
Cemetery or crematory Westminster Cemetery  
Location Westminster, Maryland  
John R. Byers

18. Funeral director Westminster, Maryland  
Address

19. 3/19 48 Registrar  
(Date rec'd by registrar)

### MEDICAL CERTIFICATION

2D. DATE OF DEATH Mar 18 1948 at 2 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19. and that I last saw him alive on 19.

Immediate cause of death Cerebral Hemorrhage DURATION

Due to Hypertensive C-V disease yrs -

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

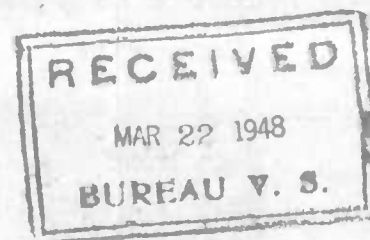
23. SIGNATURE James F. Tharsh Deputy Medical Examiner M. D. or other

Address Westminster Md Date signed 3/18/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02641

Reg. Dist. No. 74

## 1. PLACE OF DEATH:

County Carpoll  
 City or town Sykesville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 1/2 yrs 7 mo 23 da  
 Hospital, institution, or street address where death occurred Springfield State Hospital  
 How long in hospital or institution? 1 1/2 yrs 7 mo 23 da

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Ind County Baltimore  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 907 Binney St.  
 (If rural, give LOCATION) ✓  
 2. (a) If veteran, name war

## 3. (a) FULL NAME

Lola B Roberts

## 3. (b) Social Security Number

4. Sex F 5. Color or race W 8. (a) Single, married, widowed, or divorced Single  
 6. (b) Name of husband or wife  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) Sept 15th - 1900  
 8. AGE: Years 47 Months 5 Days 21 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Virginia  
(Town, county, and state)10. Usual occupation Dependent

11. Industry or business

12. Name William C Roberts13. Birthplace Virginia14. Maiden name Ida Wessels15. Birthplace Virginia16. Informant Mrs Ida B CurryAddress 907 Binney St Baltimore17. Burial Date thereof Mar 12 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Springfield Hospital Cem.Location Sykesville Md.18. Funeral director Harry KeerAddress Sykesville Md.19. Mar 12 1948 Harry Keer  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 7th 1948 at 2-25 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 13 1937 to Mar 7th 1948  
 and that I last saw her alive on Mar 7th 1948

Immediate cause of death

Coronary Occlusion

Due to

Due to Gallop 4 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W H Weston MD  
Sykesville Ind M. D. or other 3/7/48  
Address Date signed

RECEIVED

MAR 16 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02642

Reg. Dist. No. 74

## 1. PLACE OF DEATH:

County CarrollCity or town Henryton, Maryland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 month 14 days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis SanatoriumHow long in hospital or institution? Colored Branch, Henryton

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 924 Mason Street  
(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

Boyce Dean Rogers

## 3. (b) Social Security Number

248-18-9381

4. Sex

male

5. Color or race

col

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Pauline Rogers

7. Birth date of

deceased (mo., day, yr.)

July 8, 19126. (c) If alive, give age 24 years

8. AGE:

Years

Months

Days

If less than one day

35822

hrs.

min.

9. Birthplace South Carolina

(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

12. Name William Rogers13. Birthplace S. Carolina14. Maiden name Amelia Lee15. Birthplace S. Carolina16. Informant Deceased

Address

17. Buried Date thereof 4/3/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Mid CalverysLocation Baile H. Spartanburg18. Funeral director Samuel L. BrownAddress 108 W. Main St.19. March 30 19 48

(Date rec'd by registrar)

Local Deputy

Registrar

23. SIGNATURE

Richard W. Brown, M.D. M. D. or otherAddress Henryton, MarylandDate signed 3/30/48

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 19 48 at 11 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 16 19 48 to March 30 19 48and that I last saw him alive on March 30 19 48

Immediate cause of death

Pulmonary Tuberculosis

DURATION

Nov.1947

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Richard W. Brown, M.D. M. D. or otherAddress Henryton, MarylandDate signed 3/30/48



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02643

Reg. Dist. No. 74

### 1. PLACE OF DEATH:

County Carroll  
City or town Sykesville  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 31 yrs. 5 mos. 24 days  
Hospital, institution, or street address where death occurred:  
Springfield State Hospital  
How long in hospital or institution? 31 yrs. 5 mos. 24 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County \_\_\_\_\_  
City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 1408 W. Lenoir St.  
(If rural, give LOCATION)  
2. (a) If veteran, name war. \_\_\_\_\_

### 3. (a) FULL NAME

Michael Henry Rogers

### 3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) April 21, 1888

8. AGE: Years 59 Months 10 Days 24 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Baltimore City  
(Town, county, and state)

10. Usual occupation Teamster

11. Industry or business \_\_\_\_\_

FATHER 12. Name Michael W. Rogers

13. Birthplace Maryland

MOTHER 14. Maiden name Mary J. Henry

15. Birthplace New York

16. Informant Records of the Springfield St.

Address Hosp., Sykesville, Maryland

17. Burial Date thereof Mar 17, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Springfield

Location Sykesville Md.

18. Funeral director Harry Keen

Address Sykesville Md.

19. Mar 16 19 48 Harry Keen  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 19 48, at 2:15 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1 19 47 to March 15 19 48 and that I last saw him alive on March 15 19 48

Immediate cause of death Coronary thrombosis DURATION 3 hrs.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Dementia praecox, paranoid type 32 yrs.  
(Include pregnancy within 5 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: if death was due to external causes, fill in the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

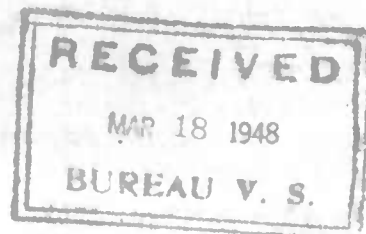
23. SIGNATURE Martin Gross, M.D. M. D. or other \_\_\_\_\_

Address Sykesville, Maryland Date signed 3/15/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Do not correct age in pencil. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 02644 76

## 1. PLACE OF DEATH:

County Carroll  
 City or town Westminster  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? life  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County Carroll  
 City or town Westminster  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Green Gables Apt. Bond St.  
 (If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

Kate McCollum Roop

## 3. (b) Social Security Number

215-07-1231

4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced widow  
 6. (b) Name of husband or wife H. Scott Roop  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) May 31, 1866  
 8. AGE: Years 81 Months 9 Days 24 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Uniontown, Md.  
 (Town, county, and state)  
 10. Usual occupation none  
 11. Industry or business

FATHER 12. Name William McCollum  
 13. Birthplace Maryland  
 MOTHER 14. Maiden name Martha Kelly  
 15. Birthplace Maryland

16. Informant Mrs. Homer L. Twigg  
 Address Hampstead, Md.

17. burial Date thereof 3/26/48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Westminster Cemetery  
 Location Westminster, Md.

18. Funeral director J. Francis Reese  
 Address Westminster, Md.

19. 3/24/48 (Date rec'd by registrar) Registrar [Signature]

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 1948 5:50a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 10, 1947 to March 24, 1948  
 and that I last saw him alive on March 24, 1948

Immediate cause of death Pneumonia of Lung DURATION 15 weeks

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [Signature] M. D. or other M.D.Address Westminster, Md. Date signed 3/24/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 26 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02645

Reg. Dist. No. 76

## 1. PLACE OF DEATH:

County Carroll  
 City or town Westminster  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 4 yrs  
 Hospital, institution, or street address where death occurred:  
243 E. Main  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Md. County Carroll  
 City or town Westminster  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 243 E. Main  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

David Ruppert

## 3. (b) Social Security Number

none

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) March 11 - 1864 6. (c) If alive, give age years

8. AGE: Years 84 Months 0 Days 12 It less than one day hrs. min.

9. Birthplace Littlestown, Pa.  
 (Town, county, and state)

10. Usual occupation Farmer ret.

11. Industry or business

12. Name Adam Ruppert

13. Birthplace Germany

14. Maiden name Catherine Bager

15. Birthplace Germany

16. Informant Mrs Catherine Fryman

Address 243 E. Main, Westminster, Md.

17. Burial Date thereof March 26 - 1948  
 (Burial, cremation, or removal, which) (month) (day) (year)

Cemetery or crematorium St John Cemetery

Location Westminster, Md.

18. Funeral director H Bankard Don

Address Westminster, Md.

19. 3/24/48 Registrar

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

2D. DATE OF DEATH Mar. 23 - 1948 at 4 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 17 to Mar. 23 - 1948

and that I last saw him alive on Mar. 21 - 1948

Immediate cause of death chronic myocarditis DURATION 5 yrs.?

Due to Senility

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

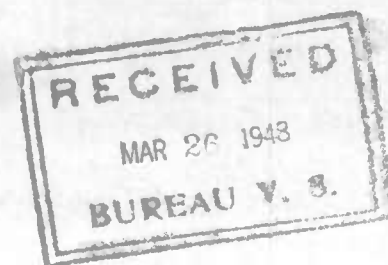
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. B. Birkington M.D. M. D. or other

Address Westminster, Md. Date signed 3-23-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 76

02646

1952

## 1. PLACE OF DEATH:

County CarrollCity or town Marbleton  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

Male

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Aug. 8, 1882

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

It less than one day

6576

hrs.

min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER  
MOTHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month)

(day)

(year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Prior to  
Mar 1448at 12:15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19.....

to

19.....

and that I last saw him alive on

19.....

Immediate cause of death

Malnutrition and exposure

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

None

Date of op.

Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

James T. Marsh Deputy Medical Examiner

M.D. or other

Address

Date signed

3-15-48

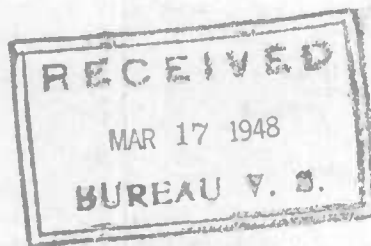
MARGIN RESERVED FOR BINDING

I

VS 415 9-45-15M

VS 415

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1640

02647

## CERTIFICATE OF DEATH

Reg. Dist. No. 75

## 1. PLACE OF DEATH:

County Carroll  
 City or town Manchester MD  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 14 years  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Carroll  
 City or town Manchester  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2. (a) if veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Donald Lee, Wenty Shaffer

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single  
 6. (b) Name of husband or wife \_\_\_\_\_

7. Birth date of deceased (mo., day, yr.) Dec. 6, 1933 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 14 Months 3 Days 25 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Manchester MD  
 (Town, county, and state)

10. Usual occupation at School

## 11. Industry or business

12. Name Roland M. Shaffer

13. Birthplace Manchester MD

14. Maiden name Mable M. Wenty

15. Birthplace Manchester MD

16. Informant Roland M. Shaffer

Address Manchester MD

17. Burial (Burial, cremation, or removal) Which? Burial Date thereof 4-3-48  
 (month) (day) (year)

Cemetery or crematory Cemetery

Location Manchester MD

18. Funeral director Jacob Wink's Sons

Address Manchester MD

19. April 3, 48 Mrs. H. P. S. Deane  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 31 19 48 at 6:45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19 \_\_\_\_\_ to \_\_\_\_\_ 19 \_\_\_\_\_  
 and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19 \_\_\_\_\_

Immediate cause of death Heart affection due to  
haemorrhage

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op. \_\_\_\_\_

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide suicide Date of Mar 31-48

Where did injury occur? Manchester Carroll MD  
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury hanging by neck Injured at work? no

23. SIGNATURE James T. Marsh, Deputy Medical Examiner

Address Manchester MD M. D. or other \_\_\_\_\_

Date signed 5/31/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 7 1948

BUREAU V. S.

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02648

Reg. Dist. No. 75

## 1. PLACE OF DEATH:

County Carroll  
 City or town Rural Millers  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Mary Bell Shaffer

## 3. (b) Social Security Number

4. Sex

Female White

5. Color or race

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Harvey S. Shaffer

7. Birth date of deceased (mo., day, yr.)

July 11, 1981

6. (c) If alive, give age

68 years

8. AGE:

Years

Months

Days

If less than one day

66813

hrs.

min.

9. Birthplace

Carroll Co. Md.

(Town, county, and state)

10. Usual occupation

House wife

11. Industry or business

MOTHER FATHER

12. Name

Lewis Bortner

13. Birthplace

Carroll Co. Md.

14. Maiden name

Maile Rabarstone

15. Birthplace

Pennsylvania

16. Informant

Harvey S. Shaffer

Address

Manchester Md.

17.

(Burial, cremation, or removal, Which?)

Date thereof

3-27-48

Cemetery or crematory

Cemetery

Location

Manchester Md.

18. Funeral director

Carol Winkler Sgus

Address

Manchester Md.

19.

(Date rec'd by registrar)

19

48

Mo.

W. P. J. Sgus

Regist.

Address

Thompson Md.

Date signed

3-24-48

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Carroll

City or town

Rural Millers  
 (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

Date

at

place

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Mar. 24

19

48

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 1 -

19

48

to

Mar. 24

19

48

and that I last saw him alive on

Mar. 24

19

48

Immediate cause of death

Coronary Occlusion

DURATION

3 da

Due to

Hypertension Cardio Renal

Due to

Vascular Disease

Other conditions

Cardiac Hypertrophy?

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Dr. E. Bushy

M. D. or other

Date signed

3-24-48

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MAR 31 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02649

Reg. Dist. No. 76

## 1. PLACE OF DEATH:

County Carroll  
 City or town Rural Westminster  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 11 years  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Carroll  
 City or town Rural Westminster  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war none

## 3. (a) FULL NAME

William F. Sharrer

## 3. (b) Social Security Number

none

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married  
 6. (b) Name of husband or wife Katherine Beacham  
 6. (c) If alive, give age 56 years  
 7. Birth date of deceased (mo., day, yr.) February 16, 1890  
 8. AGE: Years 58 Months 0 Days 28 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Westminster, Md.  
 (Town, county, and state)  
 10. Usual occupation Retired merchant  
 11. Industry or business Dairy farmer  
 12. Name Jesse C. Sharrer  
 13. Birthplace Maryland  
 14. Maiden name Minnie Wicks  
 15. Birthplace Maryland

16. Informant Mrs. William F. Sharrer  
 Address Westminster, Md.  
 17. burial Date thereof 3/18/48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Westminster Cemetery  
 Location Westminster, Md.  
 18. Funeral director J. Francis Reese  
 Address Westminster, Md.  
 19. 3/17 48 Principles  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 1948 11:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 30 1947 to Mar 15 1948  
 and that I last saw him alive on Mar 14 1948

Immediate cause of death Carcinoma of lung  
 DURATION 6 mos +

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations Pa. of left lung  
 Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Jesse F. Sharrer on D M. D. or other \_\_\_\_\_

Address Westminster Md Date signed 3/16/48

MARGIN RESERVED FOR BINDING

VS AIR 9.45.15M

T

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 18 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02650

Reg. Diat. No. 76

## 1. PLACE OF DEATH:

County Carroll  
 City or town Westminster  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 20 years  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County Carroll  
 City or town Westminster  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 6 New Windsor Road  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war none

## 3. (a) FULL NAME

William Murray Shilling

## 3. (b) Social Security Number

none

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced single  
 6. (b) Name of husband or wife  
 6. (c) If alive, give age years  
 7. Birth date of deceased (mo., day, yr.) October 22, 1866  
 8. AGE: Years 81 Months 4 Days 9 If less than one day hrs. min.

9. Birthplace Carroll County, Md.  
 (Town, county, and state)  
 10. Usual occupation farmer (retired)  
 11. Industry or business

FATHER 12. Name William Shilling  
 13. Birthplace Maryland  
 MOTHER 14. Maiden name Matilda Brothers  
 15. Birthplace Maryland

16. Informant Mrs. Addie B. Wampler  
 Address Westminster, Md.

17. burial Date thereof 3/6/48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Deer Park Cemetery  
 Location Smallwodd, Md.

18. Funeral director J. Francis Reese  
 Address Westminster, Md.

19. 3/4 48 L.K. Woodhouse  
 (Date rec'd by registrar) 19. 48 Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 2, 1948 11:58p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on Mar 2, 1948

Immediate cause of death acute cardiac DURATION 10 minutes

Decompensation acute interstitial nephritis 4 hrs

Due to chronic myocarditis 3 yrs

diabetes mellitus 10 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas R Faith

Address Westminster, Md. Date signed 3.8.48

RECEIVED

MAR 8 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02651

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

## 1. PLACE OF DEATH:

County Carroll  
 City or town Henryton, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis SanatoriumHow long in hospital or institution? Colored Branch, Henryton

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 602 S. Paca Street

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

Loretta Geraldine Smith

## 3. (b) Social Security Number

4. Sex female 5. Color or race col 6. (a) Single, married, widowed, or divorced Single

## 6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 5, 1925

8. AGE: Years 22 Months 10 Days 8 if less than one day  
 hrs. min.

9. Birthplace Baltimore, Maryland  
(Town, county, and state)10. Usual occupation Domestic

## 11. Industry or business

MOTHER FATHER  
 12. Name Robert Smith  
 13. Birthplace Unknown  
 14. Maiden name Martha Ducson  
 15. Birthplace Virginia

16. Informant Mother- Mrs. Martha DucsonAddress 602 S. Pasca Street, Balto. Md.17. Burial Date thereof 3-17-48  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Mt. Calvary CemeteryLocation Edgemoor Rd. Baltimore18. Funeral director Shelton H. HildrethAddress 918 North Hill Ave.19. March 13 19 48 Alfred R. Sandman  
(Date rec'd by registrar) Local Deputy Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 19 48 at 5:30 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
March 12 19 48 to March 13 19 48  
 and that I last saw her alive on March 13 19 48

Immediate cause of death Pulmonary TuberculosisDURATION  
Jan.  
1947

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Reuben Hoffman, M.D. M. D. or otherAddress Henryton, Maryland Date signed 3/13/48

RECEIVED

MAR 18 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

02652

76

## 1. PLACE OF DEATH:

County..... Carroll  
 City or town..... Rural Warfieldsburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 5 years  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State..... Maryland County..... Carroll  
 City or town..... Rural Warfieldsburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
none  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Emanuel Spangler3. (b) Social Security Number  
none

4. Sex..... male 5. Color or race..... white 6. (a) Single, married, widowed, or divorced..... widowed

6. (b) Name of husband or wife..... Rebecca Gachmour  
 6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)..... October 10, 1865

8. AGE: Years..... 82 Months..... 5 Days..... 20  
 If less than one day..... hrs. .... min.

9. Birthplace..... Pennsylvania  
 (Town, county, and state)

10. Usual occupation..... laborer

11. Industry or business.....

12. Name..... Conrad Spangler

13. Birthplace..... Pennsylvania

14. Maiden name..... Not known

15. Birthplace..... Not known

16. Informant..... Mrs. Melvin W. Garrett

Address..... Warfieldsburg, Md.

17. burial Date thereof..... 4/2/48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Bermudian Lutheran

Location..... Adams County, Pennsylvania

18. Funeral director..... J. Francis Reese

Address..... Westminster, Md.

19. (Date rec'd by registrar)..... 3/31 48 E. K. K...  
 Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH..... March 30 19 48, at 1:15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... 19..... to..... 19.....  
 and that I last saw him..... alive on..... 19.....

Immediate cause of death..... Coronary Occlusion DURATION.....  
 \_\_\_\_\_  
 \_\_\_\_\_

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: \_\_\_\_\_

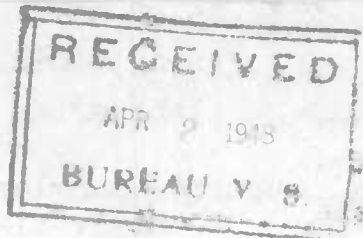
Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... James P. Moore Deputy Medical Examiner  
 M. D. or other.....  
 Address..... Westminster, Md. Date signed..... 3/31/48



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02653

83a

83

Reg. Dist. No. \_\_\_\_\_

### 1. PLACE OF DEATH:

County Carroll  
City or town Woodbine  
(If outside city or town limits, write RURAL NEAR and give town)  
Street address, hospital, or institution: Newitt Nursing Home  
Stay in hospital or inst. (yrs., or mos., or days) 12 days  
Stay in this community (yrs., or mos., or days) \_\_\_\_\_

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Carroll  
City or town New Windsor Ward No. \_\_\_\_\_  
(If outside city or town limits, write RURAL NEAR and give town)  
Street No. P. D. 1  
(If rural give LOCATION)  
2(a) IF VETERAN, NAME WAR \_\_\_\_\_

### 3. (a) FULL NAME

Ella Catherine Stonesifer

### 3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed  
6 (b) Name of husband or wife Clarence T. Stonesifer  
6 (c) If alive, give age Dead years  
7. Birth date of deceased (mo., day, yr.) Dec. 25, 1881  
8. AGE: Years 66 Months 2 Days 20 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Carroll County, Md.  
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business In her home

12. Name Philip Sumner

13. Birthplace Carroll County, Md.

14. Maiden name Eliza Beckers

15. Birthplace Carroll County, Md.

16. Informant Joseph L. Stonesifer

Address New Windsor, Md. P. D. 1

17. Burial Date thereof March 23, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Pleasant Valley Cemetery

Location Pleasant Valley, Md.

18. Funeral director J. W. Leach & Son

Address Gettysburg, Pa. P. O. Box 11

19. March 21, 1948 Ella M. Newitt  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH March 20, 1948 at 10 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1940, to Mar 20 1948 and that I last saw him alive on Mar 19 1948

Immediate cause of death Cerebral hemorrhage

Due to arteriosclerosis

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE A. Reeswilkins M. D. or other \_\_\_\_\_

Address Westminster Date signed 3/20/48

### DURATION

12 days

4 to 5 + yrs

ys

### PHYSICIAN

Please underline the cause to which death should be charged statistically.

MARGIN RESERVED FOR BINDING

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VSA15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**RECEIVED**

MAR 31 1948

**BUREAU V. S.**

Evidence for change of  
age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02654

FILM No. G 114 APR 5 1948

CERTIFICATE OF DEATH

Reg. Dist. No. 70

1. PLACE OF DEATH:

County CARROLL  
City or town Woodbine, R.F.D. # 1  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Four months

Hospital, institution, or street address where death occurred:

Hewitt Nursing Home  
How long in hospital or institution? Four months (11-10-1947)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll  
City or town Taneytown  
(If outside city or town limits, write RURAL and give nearest town)

Street No. R.F.D. # 2  
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

CHARLOTTE STULLER

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of  
deceased (mo., day, yr.)

March 25, 1869

8. AGE:

Years

Months

Days

If less than one day

78 11 17 hrs. min.

9. Birthplace Keyville, Carroll Co., Maryland

(Town, county, and state)

10. Usual occupation Housework - none recently.

11. Industry or business

FATHER

12. Name

John Stuller

13. Birthplace

Md.

MOTHER

14. Maiden name

Rebecca Stuller

15. Birthplace

Md.

16. Informant Carroll County Welfare Board

Address Westminster, Maryland

17. Burial  
(Burial, cremation, or removal. Which?)

Date thereof March 11, 1948  
(month) (day) (year)

Cemetery or crematory

Reformed Cemetery

Location

Taneytown, Md.

18. Funeral director

C. D. Fuss, Son

Address

Taneytown, Md.

19. March 11, 1948

Ethel M. Mehnerd  
Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8, 1948 at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

B-1-1948 to B-9-1948

and that I last saw him alive on 3-8-48

Immediate cause of death

Pulmonary edema

DURATION

10 d

Due to

Cardiac decompensation in mitral

Due to

Cardiac vascular

disease  
(Include pregnancy within 3 months of death)

Major findings of operations

NO

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? NO  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Dr. C. Stuller

M. D. or other

Address Westminster, Md. Date signed 3-9-48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 31 1948

BUREAU V. S.

Mr. F. me didn't have  
a pink copy. Thanking  
you

Ethel M. Mebrian

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02655

Reg. Dist. No. 74

## 1. PLACE OF DEATH:

County Carroll  
 City or town Henryton, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 22 days  
 Hospital, institution, or street address where death occurred:  
Maryland Tuberculosis Sanatorium  
 How long in hospital or institution? Colored Branch, Henryton

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County \_\_\_\_\_  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 804 W. Ostend Street  
 (If rural, give LOCATION) ✓

2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Robert Westbrook

## 3. (b) Social Security Number

4. Sex male 5. Color or race col 6. (a) Single, married, widowed, or divorced Single  
 6. (b) Name of husband or wife \_\_\_\_\_  
 7. Birth date of deceased (mo., day, yr.) March 15, 1925  
 6. (c) If alive, give age \_\_\_\_\_ years  
 8. AGE: Years 23 Months 0 Days 12 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Chester, S. Carolina  
 (Town, county, and state)  
 10. Usual occupation Laborer  
 11. Industry or business \_\_\_\_\_

12. Name Wade Westbrook  
 13. Birthplace S. Carolina  
 14. Maiden name Mamie Jackson  
 15. Birthplace S. Carolina

16. Informant Deceased  
 Address Deceased  
 17. Burial (Burial, cremation, or removal, Which?) Date thereof 3-31-48  
 Cemetery or crematory St. Columba Cemetery  
 Location St. Columba Cemetery  
 18. Funeral director Brown Son  
 Address 108 W. Montgometry

19. March 27 19 48  
 (Date rec'd by registrar) Local Deputy Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 27, 1948 at 1:40 M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
March 5 19 48 to March 27 19 48  
 and that I last saw him alive on March 27 19 48

Immediate cause of death Pulmonary Tuberculosis  
 DURATION Nov. 1947

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_  
 Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

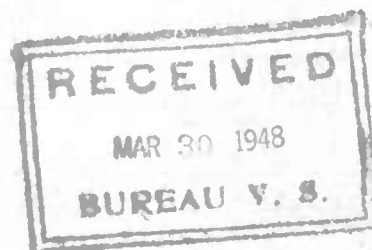
Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Robert Westbrook, M.D.  
 M. D. or other \_\_\_\_\_  
 Address Henryton, Maryland Date signed 3/27/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

MAR 30 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02656

Reg. Diat. No. 80

### 1. PLACE OF DEATH:

County Carroll Co.

City or town New Windsor  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 years

Hospital, institution, or street address where death occurred:

Back street

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town New Windsor  
(If outside city or town limits, write RURAL and give nearest town)

Street No. Back street  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

Engene Clinton Wheat

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife Isabella C. Wheat

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 8, 1879

8. AGE: Years 68 Months 5 Days 1 If less than one day hrs. min.

9. Birthplace Baltimore City, Md.  
(Town, county and state)

10. Usual occupation farm hand

11. Industry or business nursery

12. Name Zachariah Wheat

13. Birthplace Maryland

14. Maiden name Margaret O. ?

15. Birthplace Maryland

16. Informant Miss Mildred Weaver

Address New Windsor Md.

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof March 12/48  
(month) (day) (year)

Cemetery or crematory Bethel Cemetery

Location Sumo Creek, New Windsor

18. Funeral director J. E. Myers, Jr.

Address Westminster Md.

Maid 12 1948 Grand Branch

(Data rec'd by registrar)

Registrar

### 3. (b) Social Security Number

None

### MEDICAL CERTIFICATION

20. DATE OF DEATH March 9 1948 at 6 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 7 1947 to Mar 9 1948

and that I last saw him alive on Jan 17 1948

Immediate cause of death

Heart Disease

Arterio-sclerotic C.V. disease

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James T. Thomas M. D. or other

Address Waterman Md. Date signed 3/9/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 19 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02657

Reg. Dist. No. 74

### 1. PLACE OF DEATH:

County Carroll  
City or town Henryton, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 4 Months, 21 Days  
Hospital, institution, or street address where death occurred:  
Maryland Tuberculosis Sanatorium  
How long in hospital or institution? Colored Branch

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
City or town Rockville  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)  
2.(a) If veteran, name War \_\_\_\_\_

### 3. (a) FULL NAME

JOHN WILLIAMS, SR.

### 3. (b) Social Security Number

4. Sex Male 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Married  
6.(b) Name of husband or wife Gertrude Williams  
7. Birth date of deceased (mo., day, yr.) Unknown 1893  
6.(c) If alive, give age 52 years  
8. AGE: Years 55 Months ? Days ? If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Norbeck, Maryland  
(Town, county, and state)  
10. Usual occupation Laborer  
11. Industry or business \_\_\_\_\_  
12. Name Gus Williams  
13. Birthplace Maryland  
14. Maiden name Ida Botts  
15. Birthplace Maryland

16. Informant Deceased  
Address \_\_\_\_\_  
17. (Burial, cremation, or removal. Which?) burial Date thereof April 31, 1948  
(month) (day) (year)  
Cemetery or crematory Union Park  
Location \_\_\_\_\_  
18. Funeral director Robert D. Slaughter  
Address Rockville, Md.  
19. March 31, 1948 Alfred H. Brantley  
(Date rec'd by registrar) (Registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH March 31, 1948 at 6:40 P.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 10, 1948 to March 31, 1948  
and that I last saw him alive on March 31, 1948  
Immediate cause of death Pulmonary Tuberculosis  
DURATION July 1947  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)  
Major findings of operations \_\_\_\_\_  
Date of op. \_\_\_\_\_  
Autopsy results \_\_\_\_\_  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_  
23. SIGNATURE Robert D. Slaughter, M.D. M. D. or other \_\_\_\_\_  
Address Henryton, Md. Date signed 3-31-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 2 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

## 1. PLACE OF DEATH:

County CarrollCity or town Henryton, Maryland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 Months, 10 Days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis SanatoriumHow long in hospital or institution? Colored Branch

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CoCity or town Baltimore 22  
(If outside city or town limits, write RURAL and give nearest town)Street No. 117 W. Main Street

(If rural, give LOCATION)

2.(a) If veteran, name war ✓

## 3. (a) FULL NAME

PEARL VIOLA WINSTON

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female Colored Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) December 26, 19078. AGE: Years Months Days If less than one day  
40 3 4 hrs. min.9. Birthplace Sparrows Point, Balto., Md.  
(Town, county, and state)10. Usual occupation None

11. Industry or business

12. Name Walter Winston13. Birthplace N. Carolina14. Maiden name Basha Staten15. Birthplace N. Carolina16. Informant Elnora Norfleet, (Sister)Address 117 Balnew St., Dundalk, Md.17. Burial Date thereof 4/3/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Mt. CalvaryLocation Queen Anne's Del Co. Ty18. Funeral director Mr. Robert Elliott & SonAddress 1129 N. Caroline St., Balto.19. March 30, 1948(Date rec'd by registrar) Local Deputy Registrar

## MEDICAL CERTIFICATION

P.

20. DATE OF DEATH March 30, 1948 at 12:10 P.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
January 20, 1948 to March 30, 1948  
and that I last saw him alive on March 30, 1948Immediate cause of death Pulmonary Tuberculosis

DURATION

Nov1947

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert Hoffman, M.D.

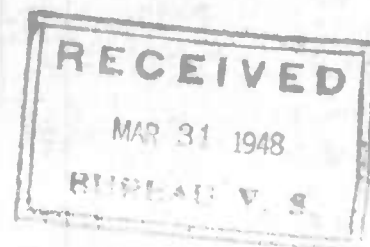
M. D. or other

Address Henryton, Md. Date signed 3-30-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02659

Reg. Dist. No. 74

## 1. PLACE OF DEATH:

County Carroll  
 City or town Henryton, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 year 10 month 17 days  
 Hospital, institution, or street address where death occurred:  
Maryland Tuberculosis Sanatorium  
 How long in hospital or institution? Colored Branch, Henryton

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Somerset  
 City or town Fairmount  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Thomas James Winston

## 3. (b) Social Security Number

229-20-2557

4. Sex male 5. Color or race col 6. (a) Single, married, widowed, or divorced Single

## 6. (b) Name of husband or wife

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) December 24, 1927

8. AGE: Years 20 Months 3 Days 6 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace West Point, Virginia  
 (Town, county, and state)

10. Usual occupation Shoe Repairer

## 11. Industry or business

FATHER 12. Name Unknown

13. Birthplace Unknown

MOTHER 14. Maiden name Martha Unknown

15. Birthplace Unknown

16. Informant Deceased

Address Fairmount and

17. burial Date thereof Apr 6 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Fairmount

Location Fairmount and

18. Funeral director Elias H. Ward

Address Marion

19. March 30 19 48 Albert R. Latham  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

P.

20. DATE OF DEATH March 30 19 48 at 8:30 M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 13 19 46 to March 30 19 48  
 and that I last saw him alive on March 30 19 48

Immediate cause of death Pulmonary Tuberculosis  
 DURATION Dec. 1945

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

\_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

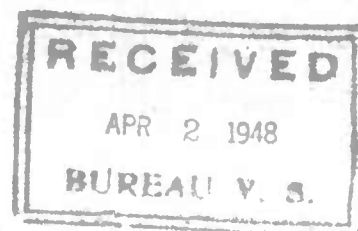
Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Reuben Hoffman, M.D.  
 M. D. or other \_\_\_\_\_

Address Henryton, Maryland Date signed 3/30/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

13/a

02660

## CERTIFICATE OF DEATH

Reg. Dist. No. 25

## 1. PLACE OF DEATH:

County... *Carroll*  
 City or town... *Manchester*  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? *9 months*  
 Hospital, institution, or street address where death occurred:  
*Long View Nursing Home*  
 How long in hospital or institution? *9 months*

## 2. USUAL RESIDENCE (HOME) OF DECEASED

(For newborn infants give residence of mother)

State... *Md.* County... *Balto.*  
 City or town... *Bidenwood*  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. *Joppa Rd.*  
 (If rural, give LOCATION)

2. (a) If veteran, name was

## 3. (a) FULL NAME

*Richard Henry Woodward*

## 3. (b) Social Security Number

## 4. Sex

*Male*

## 5. Color or race

*White*

## 6. (a) Single, married, widowed, or divorced

*Married*

## MEDICAL CERTIFICATION

20 DATE OF DEATH... *March 13* 19 *48* at *1 P.M.*

## 6. (b) Name of husband or wife

*Margaret S. Woodward*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*July 28* 19 *47* to *March 13* 19 *48*and that I last saw him alive on *March 12* 19 *48*

## 7. Birth date of deceased (mo., day, yr.)

*Sept 6-1864*

## 6. (c) If alive, give age

*85* years

## 8. AGE:

*83*

Years

*6*

Months

Days

*7*

If less than one day

hrs. min.

## 9. Birthplace

*Virginia*  
(town, county, and state)

## 10. Usual occupation

*none*

## 11. Industry or business

*none*

## FATHER

## 12. Name

*Richard H. Woodward*

## 13. Birthplace

*Virginia*

## MOTHER

## 14. Maiden name

*Susanna T. Rollard*

## 15. Birthplace

*Virginia*

## 16. Informant

*Mrs. W. Woodward - Son*

## Address

*Bidenwood - Md.*

## 17.

*Burial*  
(Burial, cremation, or removal, Which?)

## Date thereof

*3-15-48*  
(month) (day) (year)

## Cemetery or crematory

*Druid Ridge*

## Location

*Ballmon Co.*

## 18. Funeral director

*STEWART & MOWEN COMPANY*  
(W. F. WOODEN SUG.) 168 W. ANNA AVENUE

## Address

## 19.

*3/15-48*  
(Date rec'd by registrar)

## 19.

*A. W. Neduch*  
Registrar

## Immediate cause of death

*Cerebral hemorrhage*

## DURATION

## Due to

*Hypertensive Cardio. & Renal*

## Due to

*Cerebral Circulation*

## Other conditions

*Senility*

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op. *—*

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of *—*

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

## 23. SIGNATURE

*Joseph E. Bush MD*  
M. D. or otherAddress *Manassas Md.* Date signed *3-13-48*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02661

Reg. Dist. No. 75

## 1. PLACE OF DEATH:

County Carroll  
 City or town Manchester, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 year 2 mos.  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution? 1 year 2 mos.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Carroll  
 City or town Westminster, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Carroll St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Ida Gingham

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female white Single

## 6. (b) Name of husband or wife

T. Birth date of deceased (mo., day, yr.) Nov 28, 18578. AGE: Years Months Days It less than one day  
90 3 24 hrs. min.9. Birthplace Carroll Co., Md.  
(Town, county, and state)10. Usual occupation None

## 11. Industry or business

12. Name Unknown

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant Mrs. Earl Waller (Birmingham)Address Manchester, Md.17. Burial Date thereof March 24, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory KendallLocation Westminster18. Funeral director H. Bankard HonAddress Westminster, Md.19. Mar 24 1948 Mrs. W. P. S. Deener  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 1948 at 4:45 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 14 1947 to March 23 1948  
and that I last saw him alive on March 22 1948Immediate cause of death PneumoniaDURATION  
7 daysDue to Chronic Myocarditis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Joseph E. Bush M.D.

M. D. or other

Address Westminster, Md. Date signed 3-22-48

